PRINTED: 12/20/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		344002	B. WING		08/25/2007	
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS	3	A 000			
	immediate jeopardy (and to determine the the Medicare Condition Based on survey find of 08/02/07 was not at to be ongoing as evid Medical record review #39, a 44 year old fer a diagnosis of acute promitment. Upon a assessed by the med with unsteady gait. It staff interviews revearefusing to sit still, an unsteady gait on 08/1 assistance of 2 staff in to prevent injury. Sta Patient #39 required member on each side hallways. The patiend designated timeout rothroughout the day 08 interviews, staff failed while Patient #39, know gait, wandered into the Observation of the time with concrete walls and Record reviews and spatient "bumped" into on 08/19/07 at 1030 in her right eyebrow. The revealed the patient "timeout room again and the staff in the staff	follow up on the outstanding IJ) identified on 08/02/07 Hospital's compliance with ons of Participation. ings, the immediate jeopardy abated and was determined lenced by the following: v on 08/23/2007 of Patient male admitted 08/18/07 with psychosis as an involuntary admission, the patient was lical staff and nursing staff Medical record review and led the patient was agitated, d continued to walk with an 19/07, requiring the members when ambulating ff interviews revealed the assistance of a staff while ambulating in the unit t wandered in and out of the				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		344002	B. WING		08	/25/2007
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A 043	time Patient #39 fell at The patient was trans Department of an act diagnosed with an opintracranial hemorrhal subsequently transfel hospital for neurologic August 24, 2007, the identification of an impatients' health and sat 1405. The facility squalified staff for the of an agitated patient and failed to ensure the and modification of transfel with known unreoccurrence of harm to an acute care hospital with a known unstead were discussed with the 08/24/07 at 1630. The developed and imples correct the deficiencies not abated. 482.12 GOVERNING The hospital must has body legally responsible for must carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry out the fur that pertain to the government of an acute carry on the further of an acute carry out the further of an acute carry out the further of an acute carry on the further of acute carry out the further of acute carry of acute carry of acute carry of acute carry	neout room at 1405 at which and hit her head on the floor. It is care hospital at 1445 and the fracture of the skull with ge. Patient #39 was red to a tertiary care cal intensive care. Survey findings resulted in mediate jeopardy to afety beginning on 08/19/07 staff failed to provide monitoring and supervision with known unsteady gait the assessment, evaluation eatment plan for an agitated insteady gait to prevent and a fall requiring transfer bital and subsequently for 1 of 1 sampled patients dry gait (#39). The findings the administrative staff on the administrative staff on the administrative staff mented an action plan to the son 08/25/07. The IJ was a BODY The staff failed to provide monitoring and supervision with known unsteady gait to prevent and a fall requiring transfer bital and subsequently and a fall requiring transfer bital and subsequently and a fall requiring transfer bital and subsequently and a fall requiring transfer bital and a fall requiring transfer bital and subsequently and a fall requiring transfer bital and a fall requiring transfer bital and subsequently and a fall requiring transfer bital and a fall requiring transfer bital and subsequently and a fall requiring transfer bital and a fall requiring transfer	A 04			
	This CONDITION is	not met as evidenced by:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	G	 	08/25/2007	
	OVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
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A 043	reviews and staff and hospital's governing to systems were in place evaluation and modifican agitated patient with prevent reoccurrence harm, for 1 of 1 sample unsteady gait (#39). body failed to ensure and oversight for the failing to assess, evaluate treatment plan for a property of the governing coordination of medicing physician extenders of supervising physician examination and treat safe delivery of care with unsteady gait (#39). The governing body failed bylaws/hospital policicompletion of the meafter discharge for 4 degree f	ne hospital's policies, observation, medical record of physician interviews, the body failed to assure to ensure assessment, ication of treatment plan for ith a known unsteady gait to of falls, and subsequent oled patients with a known. The hospital's governing medical staff accountability quality of care provided by luate and modify the patient with recurrent injuries attents with unsteady gait to body failed to oversee and staff by failing to ensure communicate with the sand document the trendered to ensure for 1 of 1 sampled patients and 1 of 8 sampled ansferred (#4). The to enforce medical staff es to ensure physician dical record within 30 days of 4 sampled records (#50, pital's governing body failed and nursing service as o ensure registered nursing uation of an agitated patient	A	043			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	COMPLET	
		344002	B. WIN	IG_		08/2	5/2007
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(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		LD BE	(X5) COMPLETION DATE			
A 043	The hospital's nursing nursing care plan of a known unsteady gait sampled patients with hospital's nursing stain condition prior to e return to the hospital that were transferred failed to ensure mediplace by failing to ensuthentication of discidays for 4 of 4 sampl 51). The governing be systems were in place radiation exposure to shielding of patients and failing to monitor sampled staff (#1, 2 at The findings include: A) The hospital failed setting by failing to ast the treatment plan for with repeated injuries unsteady gait (#39). Cross refer to 482.1 A0144 B) The hospital failed provided ongoing asst treatment plan developatient to prevent the subsequently harm, find with a known unstead	g staff failed to update the a 44 year-old patient with to prevent a fall for 1 of 1 in unsteady gait (#39). The ff failed to assess a change mergency transfer and upon for 1 of 8 sampled patients (#4). The governing body cal records systems were in sure completion and charge summaries within 30 ed records (#50, 49, 48 and body failed to ensure e to ensure minimum patients by failing to ensure during radiation exposure, a radiation exposure for 3 of 3 and 3). If to provide care in a safe seess, evaluate and modify a 1 of 1 sampled patients is related to a known If to ensure medical staff seessment, monitoring and opment in the care of a reoccurrence of falls, and for 1 of 1 sampled patients	A	043			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULI TAG CROSS-REFERENCED TO THE APPROFIDE DEFICIENCY)	D BE COMPLETION
A 043 Continued From page 4 A 043	
C) The hospital's medical staff failed to coordinate medical services by failing to ensure physician extenders communicate with supervising physicians for 1 of 1 sampled patients with unsteady gait (#39) and 1 of 8 sampled patients with unsteady gait (#39) and 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.22 (b) Medical Staff Tag A0347 D) The hospital's medical staff failed to ensure physician extenders document examination and treatment rendered to ensure safe delivery of care for 1 of 1 sampled patients with a known unsteady gait (#39) and 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.22 (b) Medical Staff Tag A0347 E) The hospital failed to ensure medical staff assessed a change in condition prior to emergency transfer from the hospital and failed to follow hospital policy to ensure required paperwork for transfer was completed for 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.22 (b) Medical Staff Tag A0347 F) The governing body failed to enforce medical staff bylaws/hospital policies to ensure physician completion of the medical record within 30 days after discharge for 4 of 4 sampled records (#50, 49, 48, 51). ~cross refer to 482.22 (c) Medical Staff Tag A0353	

Facility ID: 956125

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
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	ROVIDER OR SUPPLIER		10	EET ADDRESS, CITY, STATE, ZIP CODE 00 S STERLING ST ORGANTON, NC 28655		
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A 043	Continued From pag	e 5	A 043			
	qualified staff to assess ongoing care needs on patient with known undelivery of safe care incidents of harm and transfer to an acute of a cross refer to 482.2 A0392 H) The hospital's nurrand evaluate the care reoccurrence of falls, 1 of 1 sampled patieng ait (#39). -cross refer to 482.2 A0395 I) The hospital's nurse change in condition pand upon return to the patients that were transcribed and upon return to the patients that were transcribed by the condition of a cross refer to 482.2 A0395 J) The hospital's nurse nursing care plan of a reoccurrence of falls, 1 of 1 sampled patieng ait (#39). -cross refer to 482.2 Tag A0396	sing staff failed to supervise e of a patient to prevent the and subsequently harm, for hts with a known unsteady 3(b)(3) Nursing Services Tag ing staff failed to assess a prior to emergency transfer e hospital for 1 of 8 sampled				

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A 043	authenticated /co-autindividual(s) responsi summaries reviewed (patient #50, 49, 48 a ~cross refer to 482.24 Records Services Ta L) The hospital failed exposure to patients during radiation expo ~cross refer to 482.24 Tag A0536 M) The hospital failed monitoring of employ of 3 sampled staff (#7 ~cross refer to 482.24 Tag A0538 482.13 PATIENT RIG	large summaries were henticated by the ble for 4 of 4 discharge completed by Physician T and 51). 4 (c) (2) (vii) Medical g A0468 to ensure minimal radiation by failing to shield patients sure. 5 (b) (1) Radiology Services 4 to ensure accurate ee radiation exposure for 3 1, 2 and 3). 6 (b) (3) Radiology Services		1115			
	Based on hospital poreviews and staff and hospital failed to protailing to assess, evalureatment plan for a prelated to a known un	atient with repeated injuries					

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A 115	Continued From pag	e 7	A	115			
A 144	setting by failing to athe treatment plan for injuries related to a k sampled patients with a cross refer to 482.1 A0144 482.13(c)(2) PATIEN SETTING	provide care in a safe ssess, evaluate and modify r a patient with repeated nown unsteady gait for 1 of 1 n an unsteady gait (#39). 3 (c)(2) Patients' Rights Tag IT RIGHTS: CARE IN SAFE	A	144			
	Based on hospital por reviews, observation interviews the hospital safe setting by failing treatment plan for a prelated to a known upsampled patients with The findings include: Review of current hon "Falls, Assessment, of dated 09/21/05, revetthe factors which planconsider treatment in prevention of falls. T	spital policy #3-11, entitled Care and Documentation" aled, "Clinical staff evaluate ce the patient at risk to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUF COMPLET	
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A 144	Review of current hon "Safety Precautions" "(Name of Hospital) of measures to protect increased risk for har are suicidal, aggress Assessing the risk of vulnerability is a cont process For vulner potentially relevant for include: Falling (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation implementation of sabut not limited to: (interventions that math harm prior to initiation interventions that math h	4. Increased nursing staff spital policy #3-19, entitled dated 07/02/07, revealed, employs precautionary patients who are at rm, including patients who live and/or vulnerable. dangerousness or inuous interdisciplinary rable patients, other actors for consideration Consideration is given to y reduce the patient's risk form of and during the fety precautions, including consultations (e.g., medical, environmentSafety cedures and Patient ents:Strict: 1. Assigned as the patient under servation. 2. Remains within of the patient to decrease the	A	144			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL		
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A 144	Psychiatrist B on 08/ "Safety Precaution L processes fragmente frail, very unsteady of Review of RN C's not (at time of admission revealed, "Ptalso of risk score of 13" documentation dated "Pt was dizzy c (with Review of Psychiatr on call) progress not revealed, "Called byShe is agitated, wa on 1:1 for vulnerabilit observe patient at al Review of RN A's (m 08/19/07 at 1205 reventire shift to present times(Psychiatrist situation at 0915. O (milligrams) m-tab (a and Benedryl 50 mg medication) x 1 (onc (medication) pass pt antipsychotic medica out p (after) leaving of patients receive medica out of locked exit do and staff. Redirecte to lay down s (withou unoriented x 4 (disor	recautions Order" written by 19/07 at 0108 revealed, evel: Strict (Thought ed, pt [patient] physically very pait." Interest dated 08/19/07 at 0150 in to the inpatient nursing unit) that unsteady gait c (with) fall Review of nursing it 08/19/07 at 0230 revealed, unsteady gait" Interest C's (primary psychiatrist edated 08/19/07 at 1000 staff. Pt. grossly psychotic alking halls, manicShe is the ty (one staff member to be a times)." Interest of the control of	A 144				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SI COMPLE		
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A 144	and call back in 1 hor stumbled into wall r/t and untied shoe strin orbital @ eyebrows. noted which was clear inch laceration. PA ((PA A) who assessed given. Pupils reactive c/o (complaints of) pa Remains unoriented baseline). Will contin of Ativan." Medical record review by PA A of an assess evaluation/modification the injury the patient. Review of Psychiatris call) progress note darevealed, "Pt extreme and presentlyshe is restless; walking or refell several times that several meds - not effrom injury; will start in Geri-chair c (with) the on wrists and ankles. Review of CNA (Cert documentation dated "Pt. 1:1 this shift per within arms length dis would try to go in and trying to touch other patients.	Ativan 2 mg (given @ 1130); ar c (with) results. Pt. (related to) unsteady gait gs and bumped R (right) Scant amount of blood aned by writer to reveal a ½ obysician's assistant) notified I pt c (with) no new orders to light and equal. 0 (no) ain, 0 swelling, bruising. At 4 (0 change from ue to monitor effectiveness of treatment plan following sustained at 1030. At D's (psychiatrist 2nd on ated 08/19/07 at 1400 by agitated the whole a.m. at 1:1 but is confused; unning away from the staff; resulted in bruises; had fective/sufficient to protect pt medically related restraints in a table top and soft restraints	A 144				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 144	attempted to climb wa wall, PA notified for in attempted to run up a time-out and went in a would take back out of objects out of floor that TO door and walked in doorway. Stood in back onto floor. RN r notified a PA and other Review of CNA B's do 08/19/07 (untimed) revulnerable for harm, I behavior this shift, ha voluntarily with the do of the doorway obserpicking at floor. Pt. In time-out, all shift. Stathe on-call doctor (Ps Dr. wrote order for pt. medication), pt. contibumped head. PA wathe hall, running up a many attempts to red went in time-out room following. Staff heard and staff ran in to assover and assessed pt. Review of RN A's not revealed, "Patient conhallucinating p (after) per (Psychiatrist C)'s encouragement to take pace in and out of ha room, bathroom. Red	to go in other rooms and still alls. After a head hit to the hjury. Pt. still climbs walls, and down halls. Pt. offered and out of time-out (TO). Pt. of TO and try to pick up at wasn't there. Pt opened in c (with) 1:1 staff standing front of wall and fell straight notified immediately, who er proper precautions" Cocumentation dated evealed, "Pt strict for mad been exhibiting bizarre d walked into time-out for open. Staff stood in front wing pt. climbing walls and ad been in and out of aff notified RN, who notified ychiatrist C) of pts. behavior, to have prn (as needed nued climbing walls and as notified, pt went back on and down hall, staff made irect with no success. Pt.	A	144			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	CLIVIER	O I ON WILDICARE &	WEDICAID SERVICES				- CINID INC	7. 0930-0391
NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP STREET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 144 Continued From page 12 remains pressured, rapid, difficult to understand @ times. Attempted to hit 1:1 staff @ 1330 (CNA A). Flight of ideas and word salad present. Walking into timeout room and sat down on mattress. Pt again hit L (left) inside of forehead on wall. Writer assessed forehead @ 1220. 2			1 ' '	, ,				
NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP SUMMARY STATEMENT OF DEFICIENCIES MORGANTON, NC 28655 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 144 Continued From page 12 remains pressured, rapid, difficult to understand @ times. Attempted to hit 1:1 staff @ 1330 (CNA A). Flight of ideas and word salad present. Walking into timeout room and sat down on mattress. Pt again hit L (left) inside of forehead on wall. Writer assessed forehead @ 1220. 2			344002	B. WIN	IG		08/2	5/2007
MORGANTON, NC 28655 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 144 Continued From page 12 remains pressured, rapid, difficult to understand @ times. Attempted to hit 1:1 staff @ 1330 (CNA A). Flight of ideas and word salad present. Walking into timeout room and sat down on mattress. Pt again hit L (left) inside of forehead on wall. Writer assessed forehead @ 1220. 2	NAME OF PR	ROVIDER OR SUPPLIER		•	l		•	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 144 Continued From page 12 remains pressured, rapid, difficult to understand @ times. Attempted to hit 1:1 staff @ 1330 (CNA A). Flight of ideas and word salad present. Walking into timeout room and sat down on mattress. Pt again hit L (left) inside of forehead on wall. Writer assessed forehead @ 1220. 2	BROUGH	TON HOSP			l			
remains pressured, rapid, difficult to understand @ times. Attempted to hit 1:1 staff @ 1330 (CNA A). Flight of ideas and word salad present. Walking into timeout room and sat down on mattress. Pt again hit L (left) inside of forehead on wall. Writer assessed forehead @ 1220. 2	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
@ that time and notified PA. (PA A) assessed pt c (with) 0 new orders. 0 c/o pain. Remains unoriented to person, place, time, situation. (0 change from baseline). Assisted to dining room where pt. refused lunch and drank 20 cc (milliliters) of fea. (Psychiatrist C) contacted @ 1230 c (with) report given of situation including fact that pt. unsteady gait, stumbling, hit head and that PA had been contacted c (with) appropriate paper work started. Orders given to give Zyprexa 5 mg (Zydis) (an antipsychotic medication) x 1. Zyprexa Zydis 5 mg given @ 1310. Continued to roam in and out of room, hallway, timeout room, bathroom. Becoming louder c (with) same speech as above present. Walked into timeout room looking @ wall and according to 1:1 staff, (CNA A) pt. fell straight back hitting head on floor @ 1415. Both RNs (writer and [RN B]) into room c (with) 3 CNA staff)1:1 staff reports unable to catch pt. before fall. Prior to fall, (Psychiatrist D) to ward @ 1345 to assess pt. and was in middle of writing orders for medical related restraints to be applied (use of Geri-Chair) for safety of patient. Order given @ 1400. Patient laying supine in floor p (after) fall @ 1405 continuing to have flight of ideas, c (with) word salad becoming almost impossible to understand verbally. Words ending in a moan as if in pain. Large amount of swelling noted on physical examination to back of head. Moaning in agony upon touch"	A 144	remains pressured, rowalking into timeout mattress. Pt again his on wall. Writer assess bruises noted to L for that time and notific (with) 0 new orders unoriented to person change from baseline where pt. refused lun (milliliters) of tea. (Pt. 1230 c (with) report of fact that pt. unsteady that PA had been corpaper work started. Some (Zydis) (an antizyprexa Zydis 5 mg (CNA A) pt. fell straig (CNA A) and (CNA A) to as of writing orders for more applied (use of Gepatient. Order given supine in floor p (after have flight of ideas, calmost impossible to ending in a moan as swelling noted on phyhead. Moaning in ag	apid, difficult to understand to hit 1:1 staff @ 1330 (CNA and word salad present. Froom and sat down on it L (left) inside of forehead ased forehead @ 1220. 2 rehead c (with) slight swelling fied PA. (PA A) assessed pt a. 0 c/o pain. Remains and drank 20 cc asychiatrist C) contacted @ given of situation including a gait, stumbling, hit head and antacted c (with) appropriate Orders given to give Zyprexa psychotic medication) x 1. given @ 1310. Continued to om, hallway, timeout room, allway, timeout room, glouder c (with) same sent. Walked into timeout and according to 1:1 staff, ght back hitting head on floor writer and [RN B]) into room1:1 staff reports unable to Prior to fall, (Psychiatrist D) assess pt. and was in middle medical related restraints to be ri-Chair) for safety of @ 1400. Patient laying er) fall @ 1405 continuing to c (with) word salad becoming understand verbally. Words if in pain. Large amount of sysical examination to back of lony upon touch"	A	144	DEFICIENCY)		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/25/2007	
	ROVIDER OR SUPPLIER		10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST ORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 144	evaluation/modification the injury the patient. Observation on 08/22 room revealed a room uncarpeted, hard flood Interview with RN A of the nurse came on downs the medication in Interview revealed the was ordered to be on vulnerability to harm agitated state and un increased risk for har harmed by other patien urse was aware the as a falls risk upon as the CNA (CNA A) assinstructed to maintain the patient within arm Interview revealed the not designated the di orders, the nursing st strictest, which is with Interview revealed the Patient #39 at approximate the patient's gait was later in the morning. patient's gait was unsobserved the patient "unsteady gait puts a Interview revealed "the (patient's) elbow to surevealed the patient walking in the hall an room. Interview revealed revealed the patient walking in the hall an room. Interview revealed	sment of the patient or on of treatment plan following sustained at 1230. 2/2007 at 1620 of the timeout in with concrete walls and an or. on 08/23/07 at 0900 revealed on the unit. on 08/23/07 at 0900 revealed on the patient #39 strict observation for because the patient's steady gait placed her at an on ming herself or being ents. Interview revealed the patient had been identified demission. Interview revealed signed to the patient was in 1:1 observation and keep	A 144			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CLIVIER	S I ON WILDICARE &	INICUICAID SERVICES				- CIVID INC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		344002	B. WIN	IG		08/2	5/2007
NAME OF PR	ROVIDER OR SUPPLIER			СТГ	DEET ADDRESS CITY STATE ZID CODE	1 00/2	3/2007
NAME OF TH	OVIDER OR OUT FIER			ı	REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST		
BROUGH	TON HOSP			ı	MORGANTON, NC 28655		
(V4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECT	TION .	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	(X5) COMPLETION DATE
A 144	Continued From page	e 14	А	144			
	redirect the patient from	equently. Interview revealed					
	the patient wandered	in and out of the timeout					
	room several times.	Interview revealed the					
	timeout room was the	e same as the seclusion					
		aled the timeout room had					
	•	floors that was used as a					
		n to isolate a patient from					
		ure the safety of all patients					
	_	bursts. Interview revealed					
		placed in the timeout room ention, but rather the patient					
		nd out of the room. Interview					
		C was on the unit and saw					
	_	mately 0900. Interview					
		0 the nurse discovered the					
	patient had not swalle	owed the morning dose of					
	Seroquil (an antipsyc	hotic medication that had					
		Interview revealed the					
	·	trist C at approximately 1000					
		behavior of "pacing the					
		he walls, poor articulation,					
		word salad" and the fact that					
		vallowed her Seroquil.					
	Interview revealed Ps	•					
		enedryl 50 mg to be given gave at 1000. Interview					
		vandered into the timeout					
		ch time she tried to sit on the					
		the floor and bumped her					
		inch laceration on her right					
		evealed PA A was on the					
		nd he "came and looked at					
	the laceration". Inter-	view revealed a Band-Aid					
	· · ·	ceration and no new orders					
		view revealed the patient					
	continued to pace an						
		, often two, CNAs and the					
		t of the timeout room.					
	Interview revealed the	e patient wouldn't stay in any					

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CLIVILIN	O I OR WILDICARE &	WEDICAID SERVICES				T CIVID INC	. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		344002	B. WIN	IG		00/0	- /0007
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NAME OF PR	OVIDER OR SUPPLIER			ı	REET ADDRESS, CITY, STATE, ZIP CODE		
BROUGHT	TON HOSP			ı	1000 S STERLING ST		
			1	N	MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 144	Continued From page	e 15	А	144			
	one place for more th	an a few seconds at the					
	time and continued to	have an unsteady gait.					
	Interview revealed the	e patient's behavior					
	remained unchanged	and the nurse notified					
		fact at 1130, at which time					
		red and given to the patient.					
		sychiatrist C did not come					
		nterview revealed at 1230					
		ndered into the timeout room					
		ad" on the wall, resulting in 2					
		ehead. Interview revealed					
	-	atient immediately after the no new orders were received.					
	-	e nurse called Psychiatrist C					
		ort the patient's behavior had					
		h time Zyprexa 5mg was					
	_	the patient. Interview					
		was given in an effort to					
	"slow her downto s	_					
	Interview revealed Zy	prexa commonly causes					
	drowsiness and "kick	s in in about 30-45 minutes,					
	based on what I've se	een". Interview revealed,					
		n eye on her." Interview					
		C did not come assess the					
	•	vealed Psychiatrist D came					
		oximately 1345. Interview					
	,	D ordered medical restraints					
		soft restraints to arms and					
	_	eing the patient walking in					
	the hall with the assis	e Geri-chair is not something					
		the unit, so the nurse called					
		to locate one. Interview					
		before the nurse could get					
		itient "fell in the timeout					
		ealed the nurse, PA and					
		to the patient, who was					
	subsequently transfer						
		department via EMS.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG		08/25/2007	
NAME OF PR	OVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 144	Continued From page	e 16	Α	144			
	CNA A was unavailable Interview with CNA B revealed CNA A was to Patient #39 on the both CNAs worked wirevealed they "split the we both worked with CNA knew the patient length at all times. In knew the patient had risk for a fall and the sprevent a fall. Interview "very unsteady when revealed the patient wher room and the batt unsteady". Interview was "real wobblyit overstepping her step the wallslooked like steps". Interview revecence to the saist the patient wher clothes down". In point (unsure of exact the timeout room and at which time CNA A the wall." Interview reported to the nurses two CNAs and PA A treatment room to cle bumped her head in trevealed the patient we treatment room but the Band-Aid on her eyes the PA asked the CNA.	on 08/23/07 at 0950 the primary CNA assigned morning of 08/19/07 but ith the patient. Interview he 1:1, but most of the day her". Interview revealed the t should be within arms terview revealed the CNA been identified as being at staff were to try to help ew revealed the patient was she walked". Interview was constantly in and out of hroom and was "still very revealed the patient's gait was like she was bumping into e she was trying to walk up healed it took both of the atient use the bathroom "hold her up for her to get herview revealed at one time) the patient went in to I CNA A was "watching her" called out, "She walked into hevealed "all of this was so.". Interview revealed the took the patient to the		1-1-7			
	Band-Aid on her eyel the PA asked the CN why the patient's spec	prow". Interview revealed A if it had been determined					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		344002	B. WIN	IG		08/2	5/2007
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		000 S STERLING ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
A 144	the patient was "very and both CNAs (one walked with her continall. Interview reveal timeout room (unsure standing in the doorw (patient) was standing to come toward us. A turned and bumped in on her forehead". Interview revealed, "I've never the timeout room with voluntarily. My under length is if they are not interview revealed the that the patient had be revealed the PA came the patient's head and be a bruise and bump patient continued to will interview revealed the patient was safe becausinto stuff with two of unterview revealed the patient was safe becaused the patient was safe walked in the halfrom bumping into stuelbow when she wou revealed at one point redirect the patient from the patient swull literview revealed with staff member she was so she wouldn't fall".	day long". Interview revealed unsteady walking in the hall" on each side of the patient) nuously when she was in the led the patient went into the e of time) and "we were vay looking at her. She g at the window and turned As she was coming she into the wall and got a knot rerview revealed the distance in doorway is more than mately 8 feet). Interview been told you have to be in an a patient if they are in there in a patient if they are in there in the timeout room." The CNAs notified the nurse in the timeout room. The end ooked at the bump on the distance in the halls. The end of the walk and pace in the halls. The end of the walk and pace in the halls. The end of the walk and pace in the halls. The end of the walk and pace in the halls. The end of the walk and pace in the halls. The end of the walk and pace in the halls. The end of the walk and pace in the halls. The end of the patient while it in an effort to "keep her off	A	144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		344002	B. WING		08/2	5/2007
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A 144	revealed, "I was tak room door and I hea (patient) was on the nurse, PA and Psycopatient, who was su acute care hospital"s EMS. Interview with PA A the PA was on the comparison of the physical assessment patients, including Prevealed the PA observealed the PA observealed the patient with a jumpy kind of patient would "missed would have to regain revealed the PA was (unsure of time) who (patient) hit her head left eyebrow I loo on it." Interview revealed into the was did not adjust the transition. Interview later "the nurse told again and I went to at her head". Interview revealed was "may bump. Interview revealed was "may bump."	watching her". Interview ing the trash past the timeout and 'Boom'. I looked and she floor". Interview revealed the hiatrist attended to the bsequently transferred to an a semergency department via on 08/23/07 at 1100 revealed unit on the morning of the had to do admission the son several newly admitted eather #39. Interview ereved the patient in the hall the her at all times". Interview erevealed the state a step now and then and the her balance". Interview is reviewing patient charts are "the nurse told me she don the wall and had cut her ked at it and put a Band-Aid the ealed the nursing staff told the ean unsteady walk and bumped all. Interview revealed the PA the eatment plan at that time or go physician of the patient's the revealed about 1-1 ½ hours me she bumped her head the timeout room and looked itew revealed the patient's the alittle reddened" from the evealed the PA did not adjust that time or notify his en or the psychiatrist of the Interview revealed the PA a while until the nurse called	A 144			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08	/25/2007
	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP COD 1000 S STERLING ST MORGANTON, NC 28655	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
A 144	away". Interview revealed the PA and Psychiatrist can order Interview revealed the head bumps. Telephone interview 08/23/07 at 1115 revealed the primary on call psycholatrist day ordered Risperdal Marteniem revealed the primary on call psycholatrist day ordered Risperdal Marteniem revealed the primary on call psycholatrist day ordered Risperdal Marteniem revealed the head bumps.	time) and said "come right realed the nurse report the ckwards and hit her head on ut room. Interview revealed rist C arrived to the timeout ne. Interview revealed they not until EMS arrived and not to an acute care hospital's rent. Interview revealed only a restrictive measures. The PA had not requested the ne psychiatrist after either of revealed the psychiatrist was the niatrist for one week. The psychiatrist was the niatrist for the hospital on revealed the nurse had revealed the nurse had revealed the psychiatrist was sexhibiting psychotic revealed the psychiatrist read to be given at that time. The nurse called again an hour rer and said the patient was the nurse called again an hour rer and said the patient was the nurse called again an hour rer and said the patient was the nurse called again an hour rer and said the patient was the nurse called that the nurse revealed the nurse r	A 14	44		

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CLIVIER	O I OR WILDICARE &	WEDICAID SERVICES				- CIVID INC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG		08/2	5/2007
NAME OF PR	OVIDER OR SUPPLIER		Į.	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/2	0/2007
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BROUGH	TON HOSP			N	MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		JLD BE	(X5) COMPLETION DATE
A 144	Continued From page	e 20	А	144			
	nurse then said the p	atient had laid on the					
		ut room and bumped her					
		erview revealed the "nurse					
		he had stumbled and hit her					
	_	ealed the information related					
	to the incident was "p	presented more like she					
	tripped and bumped I	her head". Interview					
		d not report that the patient					
		. Interview revealed the					
	· ·	re the PA had seen the					
		p and if he had concerns he					
		s supervising physician, who					
		iew revealed at that time the					
		or the patient to receive					
		ealed the nurse called again and said the patient was					
		around agitated with the 1:1					
		up and down the hall with					
	_	ed "agitated was the word					
		erview revealed, "I called					
		on call that day) to discuss					
	· ·	ive her (patient)". Interview					
	_	trist then ordered for the					
	patient to be given Zy	prexa. Interview revealed					
		that Psychiatrist D was					
	going to be making ro	ounds on the unit soon after					
	their conversation. Ir						
	_	n another unit when she					
		want a PA right now on the					
	women's ward". Inte						
	' '	ne women's ward at that time					
		aying on the floor in the					
	treatment room. Inte assessed her and se	nt her to the hospital".					
		·					
	,	with Psychiatrist D on					
		ealed she was the 2nd on					
		3/19/07 and was therefore					
	making rounds on the	e units. Interview revealed					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		344002	B. WIN	IG_		08/2	5/2007
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 S STERLING ST MORGANTON, NC 28655				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 144	morning (unsure of tir #39 with her. Intervier the level of the patient medication plans for the revealed she told her monitoring for vulnerar fallen" but didn't say we psychiatrist C did not patient, but rather that would be making rour Interview revealed nuther of the patient's conducted because they were concerned because they were all the patient had an underevealed, "When I say the only way to prever her in the Geri-chair." the Geri-chair with so to protect the patient, psychiatrist saw the patient with accident waiting to knew it they were a revealed the patient for could execute the ord interview revealed that unusual on a psychial used there and are so interview revealed and for a patient with acut revealed these patient very coordinated "unlimedication or someth PA with concerns about the patient patient with concerns about the patient patient with concerns about the patient patient patient with concerns about the patient p	lled her at some point that me) and discussed Patient we revealed they discussed at's agitation and possible treatment. Interview the patient was on 1:1 ability and had "already why. Interview revealed that ask her to go see the ask her to go see the ask her to go see the at she knew Psychiatrist D ands on the unit soon anyway. It is in a staff had not notified andition at any point, communicating with a saw the patient walking in embers." Interview revealed steady gait. Interview we what was going on I said and ther from falling was to put a Interview revealed after the patient, she thought "it was a happenthey (the staff) ware of it". Interview ell before the nursing staff at medical restraints are tric unit, but they can be	A	144			

Facility ID: 956125

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		344002	B. WING _		08/	25/2007
	ROVIDER OR SUPPLIER	•		REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 144	08/24/07 at 1530 reversement at the time of administrator at home of serious Incident Not the house supervisor investigation into the the investigation into the the investigation income record and related in interviews. Interview Analysis had been in the administrator of manager (both presecare and monitoring 08/19/07 had been a revealed after review during the internal in medical record, the manager's main concalled 911 directly, rhospital's procedure operator. Interview thought that the patic appropriately adjusted maintained 1:1 moniphysician for medicate shift on which the Consequently, nursipsychiatric physician physical and behavior #39, 44 year old pat psychosis and know failed to adequately Patient #39. As a reinjuries on 08/19/07,	distrative nursing staff on avealed the nursing staff of the fall had notified the see. Interview revealed a diffication had been done by a diffication had been done done done done done had a review of the medical ancident report, as well as staff and a diffication and the nurse done had at interview and the nurse done had at interview and the information obtained avestigation, including the administrator and nurse done had ather than following the administrator and nurse done had ather than following the of calling the in house revealed the nurse manager cent's treatment plan was ded because the nursing staff toring and called the ution adjustments throughout	A 144			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SU COMPLE		
		344002	B. WING		08/2	25/2007
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A 144	Continued From page	e 23	A 144			
A 338	hospital for emergend 482.22 MEDICAL ST	•	A 338			
	staff that operates un governing body and i	ve an organized medical der bylaws approved by the s responsible for the quality atients by the hospital.				
	Based on review of the medical record review interviews, the hospit provide accountability of care provided by fa and modify the treath recurrent injuries for a known unsteady gafailed to coordinate cophysician extenders of supervising physician examination and treat safe delivery of care with known unsteady sampled patients that hospital's medical statin condition prior to e return to the hospital that were transferred failed to enforce med policies to ensure physicial accounts of the provided to the same of the provided to the provide	vs and staff and physician al's medical staff failed to y and oversight for the quality ailing to assess, evaluate ment plan for a patient with 1 of 1 sampled patients with it (#39). The medical staff are by failing to ensure communicate with its and document the trendered to ensure for 1 of 1 sampled patients gait (#39) and 1 of 8 to were transferred (#4). The fif failed to assess a change mergency transfer and upon for 1 of 8 sampled patients (#4). The medical staff ical staff bylaws/hospital ysician completion of the 30 days after discharge for				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	344002	B. WIN	G		08/2	5/2007
NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP		•	STREET ADDRESS, CITY, STATE, ZIP CO 1000 S STERLING ST MORGANTON, NC 28655		•	
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE THE APPROPRIATE	
for 1 of 1 patients with an (#39). ~cross refer to 482.22 (b A0347 B) The hospital's medical medical services by failing extenders communicate physicians for 1 of 1 same known unsteady gait (#3 patients that were transfered to 482.22 (b A0347 C) The hospital's medical physician extenders document rendered to endocument rendered to endocument rendered to endocument transferred (#4 and that were transferred (#4 and that w	al staff failed to provide a patient to prevent to a known unsteady gait in unsteady gait reviewed. A) Medical Staff Tag al staff failed to coordinate ing to ensure physician with supervising inpled patients with a 9) and 1 of 8 sampled erred (#4). A) Medical Staff Tag al staff failed to ensure ument examination and insure safe delivery of patients with a known 1 of 8 sampled patients with a known 1 of 8 sample	A	338			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		244002	B. WING	·		
NAME OF PR	OVIDER OR SUPPLIER	344002	STF	REET ADDRESS, CITY, STATE, ZIP CODE	08/2	5/2007
BROUGHT	TON HOSP		l	000 S STERLING ST MORGANTON, NC 28655		
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A 338	transferred (#4). ~cross refer to 482.2 A0347 F) The medical staff f staff bylaws/hospital p completion of the medical staff edges after discharge for 4 of 49, 48, 51). ~cross refer to 482.22 A0353 482.22(b) MEDICAL staff must accountable to the go of the medical staff must approved by the government of the medical staff has majority of the medical staff has majority of the medical staff must individual doctor of m when permitted by Staff no staff no staff must individual doctor of m when permitted by Staff no staff no staff must individual doctor of m when permitted by Staff no staff no staff no staff must individual doctor of m when permitted by Staff no s	campled patients that were 2 (b) Medical Staff Tag ailed to enforce medical colicies to ensure physician dical record within 30 days of 4 sampled records (#50, 2 (c) Medical Staff Tag STAFF ACCOUNTABILITY at be well organized and everning body for the quality rovided to the patients. as the organized in a manner erning body. as an executive committee, a ers of the committee must	A 338	DEFICIENCY)		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08	/25/2007
	OVIDER OR SUPPLIER		1000	T ADDRESS, CITY, STATE, ZIP CODI S STERLING ST RGANTON, NC 28655	•	123/2001
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A 347	Continued From pag	e 26	A 347			
	Based on medical rephysician interviews and procedures, the to: A) The hospital's meoversight of physicial the care of a patient related to a known understanding the care of a known understanding the care of a patient related to a known understanding the care of a patient related to a known understanding the care of a patient related to a known understanding the care of the	not met as evidenced by: ecord reviews, staff and , and review of facility policies hospital's medical staff failed edical staff failed to provide in extenders and oversight in to prevent repeated injuries insteady gait for 1 of 1 teady gait reviewed (#39),				
	hospital, and failed to ensure required pap	in condition prior to and upon return to the o follow hospital policy to erwork for transfer was sampled patients that were				
	The findings include	:				
	#39 revealed the pat who was admitted or psychosis on an invo Review of the psych the Psychiatrist A up patient had been tra	view on 08/23/07 of Patient tient was a 44 year old female in 08/18/07 at 2200 for acute oluntary commitment order. iatric assessment, made by son admission, revealed the insferred from an acute care was treated for lithium toxicity				
	Psychiatrist B on 08/	recautions Order" written by /19/07 at 0108 revealed, evel: Strict (Thought				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SI COMPLE	
		344002	B. WING		08/	25/2007
	ROVIDER OR SUPPLIER		1000	T ADDRESS, CITY, STATE, ZIP CODE O S STERLING ST RGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 347	frail, very unsteady g Review of a physicial 08/19/07 at 0935 (an 08/19/07) revealed, " (milligram) po (by mo 50 mg po x 1 now - p medication administration Risperdal m-tab 2mg both given by mouth Review of Psychiatristicall) progress note darevealed, "Called by psychoticShe is agmanicShe is on 1: member to observe property of the company of	d, pt [patient] physically very ait." n's telephone order dated d signed by Psychiatrist C on Give Risperdal m-tab 2 mg uth) x 1 now and Benedryl sychosis". Review of the ation record (MAR) revealed and Benedryl 50 mg were at 1000. At C's (primary psychiatrist on ated 08/19/07 at 1000 staff. Pt. grossly tated, walking halls, I for vulnerability (one staff atient at all times)." n's telephone order (given by 08/19/07 at 1125 revealed, x 1 now. Call Dr. back in 1 allts of PRN (as needed w of the MAR revealed en by mouth at 1130. n's telephone order (given by 08/19/07 at 1300 revealed, 5 mg PO x 1 now - of the MAR revealed Zyprexa n by mouth at 1310. At D's (psychiatrist 2nd on ated 08/19/07 at 1400 ely agitated the whole a.m.	A 347			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/2	5/2007
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 347	Geri-chair c (with) the on wrists and ankles. Review of RN A's (mo 08/19/07 at 1205 reventire shift to present times(Psychiatrist C situation at 0915. Or (milligrams) m-tab (at and Benedryl 50 mg medication) x 1 (once (medication) pass pt. antipsychotic medicator (after) leaving med receive medication). locked exit doors. To staff. Redirected to till lay down s (without) sunoriented x 4 (disoriand situation). (Psyco (with) orders to give and call back in 1 hos stumbled into wall r/t and untied shoe strin orbital @ eyebrows. noted which was clear inch laceration. PA ((PA A) who assessed given. Pupils reactive c/o (complaints of) pare Remains unoriented is baseline). Will contino of Ativan."	medically related restraints in a table top and soft restraints. edication nurse) note dated ealed, "Actively hallucinating. Pacing halls, running at 20 paged and notified of ders to give Risperdal 2 mg nantipsychotic medication) (an antihistamine e). Prior to this, @ 0800 med put Seroquel (an tion) in mouthand spit it out line (place where patients Attempting to walk out of buching other patients and ime-out and encouraged to success. Remains ented to person, place, time hiatrist C) contacted again c Ativan 2 mg (given @ 1130); ur c (with) results. Pt. (related to) unsteady gait gs and bumped R (right) Scant amount of blood uned by writer to reveal a ½ physician's assistant) notified if pt c (with) no new orders e to light and equal. 0 (no) ain, 0 swelling, bruising. x 4 (0 change from une to monitor effectiveness	A 347			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		344002	B. WIN	IG		08/2!	5/2007
	COVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
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A 347	dated 08/19/07 at 150 continues to remain a Ativan 2 mg given @ orders. (Required mu Ativan). Continues to rooms, day room, tim Requiring constant re Yelling @ times but s pressured, rapid, diffi. Attempted to hit 1:1 s of ideas and word sal timeout room and sat hit L (left) inside of for assessed forehead @ forehead c (with) sligh notified PA. (PA A) a orders. 0 c/o pain. R person, place, time, s baseline). Assisted to refused lunch and dra (Psychiatrist C) conta given of situation inclugait, stumbling, hit he contacted c (with) app Orders given to give antipsychotic medicat mg given @ 1310. C of room, hallway, time Becoming louder c (w present. Walked into wall and according to straight back hitting h RNs (writer and [RN I staff)1:1 staff report fall. Prior to fall, (Psyto assess pt. and was	e medication nurse) note 00 revealed, "Patient actively hallucinating p (after) 1130 per (Psychiatrist C)'s uch encouragement to take pace in and out of hall, eout room, bathroom. direction from 1:1 staff. peech mainly remains cult to understand @ times. taff @ 1330 (CNA A). Flight ad present. Walking into down on mattress. Pt again rehead on wall. Writer 0 1220. 2 bruises noted to L nt swelling @ that time and ssessed pt c (with) 0 new temains unoriented to idituation. (0 change from 0 dining room where pt. ank 20 cc (milliliters) of tea. icted @ 1230 c (with) report uding fact that pt. unsteady ad and that PA had been propriate paper work started. Zyprexa 5 mg (Zydis) (an tion) x 1. Zyprexa Zydis 5 ontinued to roam in and out	A	347			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/	25/2007
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A 347	1400. Patient laying @ 1405 continuing to word salad becoming understand verbally. if in pain. Large amo physical examination agony upon touch' Medical record review by PA A of an assess evaluation/modification the injury the patient. Interview with RN A of the nurse came on downs the medication in Interview revealed the was ordered to be on vulnerability to harm. nurse was aware the as a falls risk upon and the CNA assigned to maintain 1:1 observation within arms reach at that since the physicidistance of observations that since the physicidistance of observations that is a same within arms length at revealed the nurse find approximately 0730, gait was "more stead morning. Interview revealed when the in 1000. Interview reverse patient at risk for falling 1:1 staff had to hold it support her". Interview in the interview i	supine in floor p (after) fall have flight of ideas, c (with) almost impossible to Words ending in a moan as unt of swelling noted on to back of head. Moaning in we revealed no documentation ament of the patient or on of treatment plan following sustained at 1230. on 08/23/07 at 0900 revealed outy at 0700 on 08/19/07 and urse for the day on the unit. In nurse knew Patient #39 strict observation for Interview revealed the patient had been identified dmission. Interview revealed the patient was instructed to tion and keep the patient all times. Interview revealed an had not designated the on on the orders, the nursing test the strictest, which is	A 347			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG_		08/2	5/2007
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A 347	1:1 staff continually whall and had to redire Interview revealed the out of the time-out rocevealed the timeout seclusion room. Interview had unpadded used as a restrictive in patient from other patient from as a restrather the patient free the room. Interview roon the unit and saw the continual	om. Interview revealed the valked with the patient in the ct the patient frequently. The patient wandered in and com several times. Interview room was the same as the review revealed the timeout walls and floors that was intervention to isolate a stients to ensure the safety of the havioral outbursts. Interview was not placed in the strictive intervention, but strictive intervention, but sely wandered in and out of evealed Psychiatrist C was the patient at approximately aled at 0930-1000 the nurse of thad not swallowed the opuil (an antipsychotic open given at 0800). The nurse called Psychiatrist C to to report the patient's the halls, trying to climb the on, nonstop talking, and word that the patient had not uil. Interview revealed	A	347			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
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NAME OF PE	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
BROUGH	TON HOSP			ı	1000 S STERLING ST		
				I	MORGANTON, NC 28655		
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A 347	Continued From page	e 32	A	347			
A 347	two, CNAs and the patimeout room. Interviwouldn't stay in any of few seconds at the tirunsteady gait. Interview hehavior remained un notified Psychiatrist C which time Ativan 2m the patient. Interview not come assess the at 1230 the patient agtimeout room and "b wall, resulting in 2 brunterview revealed Primmediately after the new orders were reconurse called Psychiatrist Dehavior time Zyprexa 5mg wapatient. Interview revegiven in an effort to "psychosis". Interview commonly causes drabout 30-45 minutes, Interview revealed, "her." Interview revealed, "her	atient was in and out of the lew revealed the patient one place for more than a me and continued to have an iew revealed the patient's inchanged and the nurse of this fact at 1130, at a g was ordered and given to revealed Psychiatrist C did patient. Interview revealed gain wandered into the umped her head" on the uises to her left forehead. A A assessed the patient second "bump" and no eived. Interview revealed the trist C again at 1310 to report had not changed, at which as ordered and given to the realed the Zyprexa was slow her downto stop the w revealed Zyprexa was solven and "kicks in in based on what I've seen". We were keeping an eye on aled Psychiatrist C did not tent. Interview revealed up to the unit at	A	347			
	house supervisor to le revealed that at1405,	ocate one. Interview before the nurse could get					
		tient "fell in the timeout ealed the nurse, PA and					
	I TOOLIT . ILLUI VIOVV TOV	Jaioa dio Haloo, i / Calla	1		T. Control of the Con		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		
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A 347	subsequently transfer hospital's emergency Interview with PA A of the PA was on the un 08/19/07 because he physical assessments patients, including Parevealed the PA obse "with two CNAs with I revealed the patient's with a jumpy kind of vipatient would "miss a would have to regain revealed the PA was (unsure of time) wher (patient) hit her head left eyebrowI looked it." Interview revealed PA the patient had an her head into the wall did not adjust the treat notify his supervising condition. Interview revealed the nurse told ragain and I went to that her head". Interview forehead was "mayb bump. Interview revealed the treatment plan at supervising physician Interview revealed the nurse rebackwards and hit he timeout room. Interview interview revealed the nurse rebackwards and hit he timeout room. Interview	to the patient, who was reed to an acute care department via EMS. In 08/23/07 at 1100 revealed at on the morning of had to do admission so n several newly admitted attent #39. Interview erved the patient in the hall ther at all times". Interview agait was "a little unsteady walk". Interview revealed the astep now and then and ther balance". Interview reviewing patient charts in "the nurse told me she on the wall and had cut her did at it and put a Band-Aid on at the nursing staff told the nunsteady walk and bumped it. Interview revealed the PA atment plan at that time or physician of the patient 's revealed about 1-1 ½ hours me she bumped her head the timeout room and looked are revealed the PA did not adjust	A	347			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		1000	T ADDRESS, CITY, STATE, ZIP CODE O S STERLING ST RGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 347	the patient until EMS patient to an acute car department. Intervier psychiatrist can orde Interview revealed the nursing staff to call the head bumps. Telephone interview 08/23/07 at 1115 revibeen on staff at the head the Interview revealed the primary on call psychological psycho	revealed they attended to arrived and transported the are hospital's emergency we revealed only a "restrictive measures". PA had not requested the repsychiatrist after either of with Psychiatrist after either of ealed the psychiatrist had ospital for one week. Psychiatrist was the iatrist for the hospital on evealed the nurse had st in the morning (unsure of a had not swallowed her opuil and the patient was exhibiting psychotic evealed the psychiatrist tab to be given at that time. Per and said the patient was wouldn't stop walking. Psychiatrist then ordered and Benedryl are ordered to time for acute psychosis, d not order it that way in this tient was very small and thin. Per and said the patient was unuse called the out one hour later and said the patient was very small and thin. Per and said the patient was very small and the patient was very small and the patient was very small a	A 347			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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A 347	tripped and bumped in revealed the nurse did had an unsteady gait psychiatrist was award patient after the bump should have called his an internist. Intervipsychiatrist ordered for Ativan. Interview revabout 1½ hours later restless and walking CNA having to walk under. Interview reveal they kept using". Interview reveal they kept using". Interview revealed the psychiatrist D - 2nd what else we could go revealed the psychiatrist knew going to be making retheir conversation. In Psychiatrist C was or "heard them say they women's ward". Interpsychiatrist went to the and the patient was lateratment room. Interview 108/25/07 at 0915 revocall psychiatrist on 08 making rounds on the Psychiatrist C had camorning (unsure of time 439 with her. Interview 108 with her.	presented more like she her head". Interview d not report that the patient interview revealed the re the PA had seen the pand if he had concerns he is supervising physician, who hew revealed at that time the port the patient to receive ealed the nurse called again and said the patient was around agitated with the 1:1 up and down the hall with red "agitated was the word erview revealed, "I called on call that day) to discussive her (patient)". Interview rest then ordered for the prexa. Interview revealed that Psychiatrist D was bounds on the unit soon after the review revealed the manother unit when she want a PA right now on the role women's ward at that time and another unit when she women's ward at that time and her to the hospital". With Psychiatrist D on ealed she was the 2nd on 8/19/07 and was therefore the units. Interview revealed lled her at some point that me) and discussed Patient the wrevealed they discussed the agitation and possible and the patient and possible and the province of the point that me) and discussed Patient they revealed they discussed the patient possible and possi	A 347			

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NAME OF PR	OVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE		
BROUGHT	TON HOSP			1	000 S STERLING ST		
				N	MORGANTON, NC 28655		
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A 347	Continued From page	e 36	A	347			
	revealed she told her	the patient was on 1:1					
	monitoring for vulnera	ability and had "already					
	_	why. Interview revealed that					
	Psychiatrist C did not	ask her to go see the					
	patient, but rather tha	at she knew Psychiatrist D					
	would be making rou	nds on the unit soon anyway.					
		rsing staff had not notified					
	her of the patient's co						
	because they were co	•					
		view revealed Psychiatrist D					
		proximately 1345 for rounds.					
		saw the patient walking in					
		embers." Interview revealed					
	-	steady gait. Interview w what was going on I said					
		ent her from falling was to put					
		' Interview revealed she felt					
		oft restraints was necessary					
		Interview revealed after the					
		patient, she thought "it was					
		o happenthey (the staff)					
	knew itthey were av	* * * * * * * * * * * * * * * * * * *					
	revealed the patient f	ell before the nursing staff					
	could execute the ord	der for medical restraints.					
		at medical restraints are					
	unusual on a psychia	tric unit, but they can be					
		ometimes necessary.					
		unsteady gait is uncommon					
		te psychosis. Interview					
		nts' movements are often					
	_	ess they have too much					
		ning". Interview revealed a					
		out a patient could contact cian (an internist) or the					
	psychiatrist for guida	,					
	payornamat ioi guldal	ilice.					
	Consequently nursin	g services, medical and					
		s failed to coordinate the					
		ral care needs of Patient					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		344002	B. WING		08	/25/2007
	ROVIDER OR SUPPLIER		1000	r Address, City, State, ZIP Code s sterling st rganton, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 347	#39, 44 year old patie psychosis and known failed to adequately selection of the hose of the hose of the Hospitals, Reference of the Hospitals of the Hospitals, Reference	ent with a diagnosis of unsteady gait. Facility staff upervise the wandering of sult, Patient #39 sustained 3 at 1030, 1230 and 1405, ig transfer to an acute care by treatment. Dital's "Medical Transfer to erral" policy effective reveals "II. B. 1. Every in attending to contact the receiving facility there are difficulties or the receiving facility, this is edical record. If it is an into transport by EMS in and inform the receiving facility to the attending into the contact the receiving facility in the action of the receiving facility in the receiving fac	A 347			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	G		08/2	5/2007
	ROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 347	revealed a pregnancy negative. Review of a physical exam dictate patient's "LMP (last mer menses and her progname progress not documented "Patient and came out reques red blood running dostated 'I think I had a reports a history of mevaluated by PA (Phycalled EMS (emerger transported to (acute record revealed no as documented when the bleeding and no documented when the bleeding and no documented of last meconsciousness. Further evealed no physician patient and no documentation of what transferred or returned documentation of the return from the acute department. Review of the transferemergency department and the pregnancy department and the pregnancy test on 07 revealed the patient we (certified nursing assistance).	ecords from Hospital C's ED y test dated 07/25/2007 was the physician's history and ed 07/28/2007 revealed the menstrual period): patient has periods are irregular." es dated 07/29/2007 at 1225 was in restroom this AM ting help. Patient had bright wn both inner thighs. Patient miscarriage.' Patient iscarriages. Patient ysician's Assistant). PA may transport). EMS Hospital B)." Review of the essessment of the vital signs the patient reported the mented assessment of the duration of bleeding, enstrual period or level of mer review of the record on's order to transfer the mentation of an examination	A	347			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN			08/2	5/2007
NAME OF PR	OVIDER OR SUPPLIER			100	ET ADDRESS, CITY, STATE, ZIP CODE 00 S STERLING ST DRGANTON, NC 28655	1 00/23	5/2007
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
A 347	of "dysmennorrhea" a discharged. Further reveal a time of discharged (PA B) recome check the patiethe bathroom stall. Bnot poolingsanita said it had just started her. She was afraid. was having a miscarrexam at that time. If urgently. There was feel she needed to be in an emergency roor referral to specialty scall EMSI don't retransfer paperwork. Inot write an order to the not call the ED physical did not document the past year, we dor with (Hospital B's ED with us. They are we patients back. It is a them." 482.22(c) MEDICAL staff must to carry out its response.	ere completed in the int. Review of the ED sation revealed a diagnosis and the patient was review of the record failed to arge. 107 at 0830 with the PA that 10/2007 when the patient was wealed he was asked to int. He stated "She was in lood was flowing out of her ary pad was soaked. She did and was not normal for She said she thought she itage. I did not do a vaginal elt she needed to go out a physician on call. I did not de delayed. She needed to be inneeded immediate ervices. I asked telecom to emember if I completed the transfer the patient I did can. I did call the ED nurse. at I called the ED nurse. at I called the ED nurse. The physicians won't talk rried that we won't take the waste of time trying to call STAFF BYLAWS Stratation of the ED stratation of the sation of the trying to call stratations.		347			
	This STANDARD is	not met as evidenced by:					

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST		344002	B. WIN	G		08/2	25/2007	
BROUGHTON HOSP MORGANTON, NC 28655			•	1000	S STERLING ST	•		
	PREFIX (EACH DEFICIE	BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE	
A 353 Based on policy and procedure review, medical records department reports review, staff interview, and physician interview, the hospital failed to enforce Medical Staff Bylaws/hospital policies, by failing to ensure physician completion of medical records within 30 days of discharge for 4 of 4 sampled discharge summaries completed by Physician T (patient #50, 49, 48 and 51). The findings include: Review of the hospital's "Record Entries, Quantitative" policy dated 05/25/2007, revealed "Discharge Summary No later than 15 Days (Dictated) No later than 30 Days (Complete)". Review of "Medical Records Delinquency Rate for Chart Completion" report dated June 2006 - June 2007 revealed the "Target" Delinquency Rate of 25%. Review of the report revealed delinquent record rates ranging from 40% to 69%. Review of the report revealed delinquent record rates ranging from 40% to 69%. Review of the report revealed the two leading causes of delinquent records are. Discharge Summary not dictated (16.9% to 53.8%), and Discharge Summary dictated late (4.9% to 30.6%). Interview on 08/24/2007 at 1340 with the Health Information Management Manager revealed the hospital has had an increase in delinquent records since December 2006. The interview revealed the system in place at this time is for dictation to be completed via telephone, which has limits due to ability to call into the system and phone availability. The interview revealed the hospital is going to be transitioning to Digital Dictation when the equipment is available. The interview revealed medical records staff monitor delinquent of del	Based on policy ar records department interview, and physical failed to enforce Mipolicies, by failing of medical records 4 of 4 sampled distriby Physician T (pail The findings included Review of the hosp Quantitative" policy "Discharge Summa (Dictated) No later Review of "Medical Chart Completion" 2007 revealed the 25%. Review of the record rates ranging of the report reveal delinquent records dictated (16.9% to Summary dictated Interview on 08/24. Information Manage hospital has had a records since Decervealed the system dictation to be combas limits due to all phone availability. hospital is going to Dictation when the interview revealed delinquency rates and the system of the	review, staff rview, the hospital ff Bylaws/hospital physician completion days of discharge for mmaries completed 49, 48 and 51). cord Entries, 6/25/2007, revealed er than 15 Days bays (Complete)". Delinquency Rate for ted June 2006 - June Delinquency Rate of evealed delinquent % to 69%. Review to leading causes of harge Summary not and Discharge for to 30.6%). 340 with the Health enager revealed the en in delinquent to 6. The interview er at this time is for a telephone, which all into the system and riew revealed the tioning to Digital and is available. The ecords staff monitor weekly send non	A	353				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		344002	B. WIN	IG		08/2	5/2007
	ROVIDER OR SUPPLIER		•	1	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 353	the Clinical Director in delinquent record state the Medical Records means to enforce the the records timely. To Clinical Director is resequirements with progression of a Locassist in "catching uphaving the physician discharge summaries. Interview on 08/25/20 Director revealed the Medical Records delinterview revealed the Medical Records delinterview revealed the physicians leave and positions, 3 of which The interview revealed the physicians leave and positions, 3 of which The interview revealed are covering the responen positions. The Department Clinical I providers in their depleaves then the Directompletion of any deprovider. The interview authorized overtime to complete delinquent caught up can be a position of the interview revealed be removed from clinical to catch up when the rate of 50%. The interview revealed delinquent records. The interview revealed the removed from clinical to catch up when the rate of 50%. The interview revealed the removed from clinical to catch up when the rate of 50%. The interview revealed the removed from clinical to catch up when the rate of 50%. The interview revealed the removed from clinical the removed f	ation. The interview revealed is also notified of provider atus. The interview revealed Manager does not have requirement to complete the interview revealed the sponsible to enforce the oviders. The interview of the hospital started to use um Tenens Physician to or on delinquent records by complete delinquent so. 2007 at 1435 with the Clinical Director is aware of the inquency rates. The enospital had some currently has 6 vacant are newly created positions. The interview revealed Directors are responsible for consibilities included in the interview revealed Director is responsible for linquent records of that the inquency rates in order to records, stating "getting providers in order to records, stating "getting problem within regular hours." The dindividual providers may sical areas for a day, in order to reach a delinquent record derview revealed "I am and help" catching up on The interview revealed the	A	353			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	(X3) DATE SUI	
		344002	B. WIN	G		08/2	5/2007
	ROVIDER OR SUPPLIER	,	•	100	ET ADDRESS, CITY, STATE, ZIP CODE 0 S STERLING ST DRGANTON, NC 28655	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 353	Directors office is resent Physician T's dictation summaries. The interior is not involved in the the discharge summaries hospital. The intervior requirement for providischarge summaries for accuracy and condischarge from (4 months prior to Price Review of the discharge). Review failed to reveal author (1 months prior to Price Review of the discharge) from (1 months prior to Price Review of the discharge). Review failed to reveal author (2 months prior to Price Review of the discharge) from (4 months prior to Price Review of the discharge) from (4 months prior to Price Review of the discharge). Review failed to reveal co-ausummary by the physician T dictated O7/06/2007 (5 months discharge). Review failed to reveal co-ausummary by the physician T dictated O7/06/2007 (5 months discharge). Review failed to reveal co-ausummary by the physician T dictated O7/06/2007 (5 months)	ew revealed the Clinical sponsible for directing on of delinquent discharge enview revealed Physician T patient care, and completes ary as a service to the ew revealed there is no ders to co-authenticate the scompleted by Physician T, inpleteness. 08/25/2007 revealed patient the hospital on 02/09/2007 eysician T's appointment). It is after the patients of the discharge summary entication by Physician T. 08/25/2007 revealed patient the hospital on 05/11/2007 eysician T's appointment). It is appointment the hospital on 05/11/2007 eysician T's appointment). It is appointment the discharge summary on safter the patients of the discharge summary on safter the patients of the discharge summary entication by Physician T. 08/25/2007 revealed patient the hospital on 02/09/2007 eysician T's appointment). It is appointment the hospital on 02/09/2007 eysician T's appointment). It is appointment the hospital on 02/09/2007 eysician T's appointment). It is appointment the discharge summary revealed the discharge summary on the discharge summa	A	353			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		244002	B. WIN		<u> </u>		
NAME OF PR	OVIDER OR SUPPLIER	344002		STR	EET ADDRESS, CITY, STATE, ZIP CODE	08/2	5/2007
BROUGH	TON HOSP				000 S STERLING ST IORGANTON, NC 28655		
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A 353	Continued From page	e 43	А	353			
A 385	#51 discharged from (4.5 months prior to F Review of the dischar Physician T dictated to 07/02/2007 (6 months discharge). Review of failed to reveal co aut summary by the physiciant's treatment du 482.23 NURSING SE	of the discharge summary thentication of the discharge dician responsible for the uring the hospitalization. ERVICES we an organized nursing 24-hour nursing services. must be furnished or	Α	385			
	Based on review of the medical record review physician interviews, organized nursing selfailed to provide superevaluate and adjust the assure trained staff was care for a patient with	vs, observation and staff and the hospital failed to have an rivice. The registered nurse existence by failing to assess, the treatment plan and were assigned to provide a repeated injuries related to it for 1 of 1 sampled patients (#39).					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		344002	B. WING			08/25/2	2007
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 1000 S STERLING ST MORGANTON, NC 2	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
A 385	ongoing care needs of with an unsteady gair with known unsteady safe care to prevent harm and a fall required acute care hospital. -cross refer to 482.2 A0392 B) The hospital's nure and evaluate the care injuries related to a known sampled patients with -cross refer to 482.2 A0395 C) The hospital's nure change in condition pand upon return to the patients that were transplant to the patients that were transplant to a known sampled patients with -cross refer to 482.2 A0395 D) The hospital's nure nursing care plantinguries related to a known sampled patients with -cross refer to 482.2 Tag A0396 E) The hospital's nure physician's order for patient's blood pressions.	ess and supervise the of 1 of 1 sampled patients at (#39), an agitated patient gait to ensure the delivery of the reoccurrent incidents of ring immediate transfer to an a sing staff failed to supervise a of a patient with repeated nown unsteady gait for 1 of 1 an unsteady gait (#39). 3(b)(3) Nursing Services Tag rsing staff failed to assess a prior to emergency transfer a hospital for 1 of 8 sampled ansferred (#4). 3(b)(3) Nursing Services Tag rsing staff failed to update of a patient with repeated nown unsteady gait for 1 of 1 an unsteady gait (#39). 3(b)(4) Nursing Services sing staff failed to follow the a medical alert to obtain the	A 3	85			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		344002	B. WING	§		08/2	5/2007
	OVIDER OR SUPPLIER	•		1000	T ADDRESS, CITY, STATE, ZIP CODE S STERLING ST RGANTON, NC 28655		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 385	Continued From page of 21 sampled open in	records (#45).	AS	385			
A 392	A0404	3 (c) Nursing Services Tag 6 AND DELIVERY OF CARE	AS	392			
	practical (vocational) to provide nursing ca There must be super each department or r	registered nurses, licensed nurses, and other personnel re to all patients as needed. visory and staff personnel for nursing unit to ensure, when te availability of a registered					
	Based on hospital por reviews, observation interviews, the hospit qualified staff to asset ongoing care needs of known unsteady gait with unsteady gait (#safe care to prevent)	not met as evidenced by: licy review, medical record and physician and staff tal failed to provide adequate ess and supervise the of an agitated patient with for 1 of 1 sampled patients 39) to ensure the delivery of the reoccurrent incidents of ring immediate transfer to an					
	The findings include:						
		spital policy #3-11, entitled Care and Documentation"					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	\ , ,	(X3) DATE SURVEY COMPLETED	
			A. BUILDING				
		344002	B. WING		08	/25/2007	
	ROVIDER OR SUPPLIER		1000	T ADDRESS, CITY, STATE, ZIP CODE DIS STERLING ST RGANTON, NC 28655	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
A 392	dated 09/21/05, reveathe factors which place consider treatment in prevention of falls. The limited to:3. Medical nursing staff supervises. Review of current hose "Safety Precautions" "(Name of Hospital) emeasures to protect processed risk for har are suicidal, aggressised Assessing the risk of vulnerability is a context process For vulner potentially relevant fainclude: Falling Context in the process in the process of patient to expect the patient of safe but not limited to: Context in the process of patient injury to the process of patient injury to the psychosis on an involved the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychiatrist A upopatient had been trained to: And the process of the psychi	aled, "Clinical staff evaluate be the patient at risk to terventions for the his includes, but is not sation reviews. 4. Increased sion" spital policy #3-19, entitled dated 07/02/07, revealed, employs precautionary batients who are at m, including patients who ve and/or vulnerable. dangerousness or inuous interdisciplinary able patients, other actors for consideration consideration is given to by reduce the patient's risk for an of and during the fety precautions, including consultations (e.g., medical, environmentSafety cedures and Patient ents:Strict: 1. Assigned as the patient under servation. 2. Remains within of the patient to decrease the	A 392				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/	25/2007
	COVIDER OR SUPPLIER		1000	T ADDRESS, CITY, STATE, ZIP CODE O S STERLING ST RGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 392	Continued From pag	e 47	A 392			
	completed on 08/19/0 patient's fall risk lever. Review of "Safety Proposition of the Prop	ed, pt [patient] physically very ait." tes dated 08/19/07 at 0150 to the inpatient nursing unit) has unsteady gait c (with) fall eview of nursing 1 08/19/07 at 0230 revealed,) unsteady gait" edication nurse) note dated ealed, "Pacing halls, stumbled into wall r/t gait and untied shoe strings) orbital @ eyebrows" te dated 08/19/07 at 1500 to pace in and out of hall, neout room, and to timeout room and sat et again hit L (left) inside of riter assessed forehead @ ed to L forehead c (with) et time(Psychiatrist C) (with) report given of ct that pt. unsteady gait, Continued to roam in and out eout room, anto timeout room looking @				
	contacted @ 1230 c situation including fac stumbling, hit head of room, hallway, tim bathroomWalked i wall and according to	(with) report given of ct that pt. unsteady gait, Continued to roam in and out eout room,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		344002	B. WING		08/	25/2007
	ROVIDER OR SUPPLIER		100	ET ADDRESS, CITY, STATE, ZIP CODE 10 S STERLING ST DRGANTON, NC 28655	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRE		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CTION SHOULD BE COMPLET O THE APPROPRIATE DATE	
A 392	staff reports unable to to fall, (Psychiatrist D pt. and was in middle related restraints to be for safety of patient. Review of CNA (Cert documentation dated "Pt. 1:1 this shift pergo in and out of other other patients, attemptime pt would be redi ineffective. RN notific wall, PA notified for in attempted to run up a time-out and went in opened TO door and standing in doorway. fell straight back onto Review of CNA B's d 08/19/07 (untimed) revulnerable for harm voluntarily with the dof the doorway obserpicking at floor. Pt. h time-out, all shift. State Observation on 08/22 room revealed a roor uncarpeted, hard floot Interview with RN A of the nurse came on downs the medication in Interview revealed the was ordered to be on vulnerability to harm.	o catch pt. before fall. Prior) to ward @ 1345 to assess of writing orders for medical e applied (use of Geri-Chair) Order given @ 1400" Iffied Nursing Assistant) A's 08/19/07 at 1505 revealed, volunerbilityPt. would try to repers rooms, trying to touch oring to climb walls, each rected by staff. Redirection edAfter a head hit to the njury. Pt. still climbs walls, and down halls. Pt. offered and out of time-out (TO)Pt walked in c (with) 1:1 staff Stood in front of wall and ofloor" Documentation dated evealed, "Pt strict for had walked into time-out or open. Staff stood in front ving pt. climbing walls and ad been in and out of aff notified RN" 2/2007 at 1620 of the timeout or with concrete walls and an or. on 08/23/07 at 0900 revealed or on the day on the unit. er nurse knew Patient #39	A 392			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG		08/2	5/2007
	OVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 392	the CNA (CNA A) assinstructed to maintain the patient within arm Interview revealed that not designated the disorders, the nursing st strictest, which is with Interview revealed the when the nurse obsellaterview revealed "urisk for falling". Intervhad to hold her (patienterview revealed the out of the time-out rocrevealed the timeout seclusion room. Intervom had unpadded used as a restrictive in patient from other patient from other patient from other patient from the patient room. Interview reverseled 1:1 monitoring by the CNA sitting or observing the patient room. Interview reverseled in the timeout intervention, but rather wandered in and out revealed the patient was on head, resulting in a 1/2 eyebrow. Interview recontinued to pace and accompanied by one, patient was in and out interview revealed the one place for more the	dmission. Interview revealed signed to the patient was a 1:1 observation and keep as reach at all times. At since the physician had estance of observation on the aff "always assumes the nin arms length at all times". The patient's gait was unsteady eved the patient at 1000. The patient at 1000. The patient wandered in and the patient was the same as the patient to ensure the safety of the patient was not room as a restrictive er the patient freely of the room. Interview wandered into the timeout the time she tried to sit on the the floor and bumped her the patient freely or the patient was the patient wandered into the timeout the floor and bumped her the floor and bumped her the patient was the patient was the patient was the patient was the patient wandered into the timeout the floor and bumped her the patient was the patien	A	392			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER			10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST IORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 392	the patient again wan and "bumped her hea bruises to her left fore Psychiatrist D came to approximately 1345. Psychiatrist D ordered Geri-chair with soft red 1400, after seeing the with the assistance of revealed the Geri-chair often used on the unithouse supervisor to larevealed that at1405, the Geri-chair, the paroom". CNA A was unavailable Interview with CNA B revealed CNA A was to Patient #39 on the both CNAs worked were vealed they "split the weboth worked with CNA knew the patient length at all times. In knew the patient had risk for a fall and the sprevent a fall. Interview "very unsteady when revealed at one point patient went in to the was "watching her" at out, "She walked into revealed "all of this we Interview revealed the supervised they are all the walked into revealed "all of this we Interview revealed they are all of this we Interview revealed they are all of this we Interview revealed they are all of this we Interview revealed they are they ar	e patient's behavior Interview revealed at 1230 dered into the timeout room ad" on the wall, resulting in 2 ehead. Interview revealed up to the unit at Interview revealed de medical restraints with a estraints to arms and legs at the patient walking in the hall of two CNAs. Interview air is not something that is the, so the nurse called the cocate one. Interview before the nurse could get tient "fell in the timeout ble for interview. on 08/23/07 at 0950 the primary CNA assigned morning of 08/19/07 but ith the patient. Interview is 1:1, but most of the day her". Interview revealed the t should be within arms terview revealed the CNA been identified as being at staff were to try to help ew revealed the patient was she walked". Interview (unsure of exact time) the timeout room and CNA A t which time CNA A called	A	392			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG		08/2	5/2007
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 1000 S STERLING ST MORGANTON, NC 28655		000 S STERLING ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
A 392	Interview revealed "the long". Interview reverse unsteady walking in to on each side of the protection	r head in the timeout room. his behavior went on all day aled the patient was "very he hall" and both CNAs (one atient) walked with her he was in the hall. Interview went into the timeout room "we were standing in the her. She (patient) was hw and turned to come has coming she turned and hand got a knot on her revealed the distance from horway is more than arms has feet). Interview revealed, hyou have to be in the timeout hey are in there voluntarily. he strict arms length is if heout room." Interview horified the nurse that the her head. Interview revealed ho walk and pace in the heled the CNA did not feel like hecause "she was still he two of us watching her	A	392			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/:	25/2007
	OVIDER OR SUPPLIER		1000	T ADDRESS, CITY, STATE, ZIP CODE O S STERLING ST RGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
A 392	the patient and did not at the patient's side in to prevent the patient subsequently suffering. Consequently, the number of the patient of th	into the timeout room with of understand the need to be in the timeout room in order from falling and g injury. It is staff on duty on intain continuous monitoring a year old female patient with it, who had been identified dmission and who had a 1:1 monitoring due to result, the patient sustained 3 at 1030, 1230 and 1405, to be transferred to an acute regency treatment. PERVISION OF NURSING the timeout room with the patient sustained 3 at 1030, 1230 and 1405, to be transferred to an acute regency treatment.	A 392			
	Based on hospital por reviews, observation interviews the hospita A) supervise and evaluith repeated injuries unsteady gait for 1 of unsteady gait (#39), a B) assess a change if emergency transfer a hospital and failed to ensure required papers.	1 sampled patients with an and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08	/25/2007
	ROVIDER OR SUPPLIER		100	ET ADDRESS, CITY, STATE, ZIP CODE 00 S STERLING ST DRGANTON, NC 28655	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 395	transferred (#4). The findings include: A) Review of current entitled "Nursing Ass dated 02/26/07, rever (RN)assesses the related to the reason health statusThe acontinues throughout The nurse evaluatesneeds to determineIndividualized nursupon the data collect assessmentInterver changed as needed afrequency, modality, Review of current hos "Falls, Assessment, Odated 09/21/05, rever the factors which place consider treatment in prevention of falls. The limited to:3. Medic nursing staff supervis Review of current hos "Safety Precautions" "(Name of Hospital) of measures to protect princreased risk for har are suicidal, aggressi Assessing the risk of vulnerability is a cont processFor vulner potentially relevant fare	hospital policy #I-38, essment and Plan of Care" aled, "The Registered Nurse patient's immediate needs for admission and current ssessment process the patient's hospitalization. the patient's physical the plan for nursing care ing interventions are based ed in the nursing entions are updated and and include rationale, and staff responsibility" spital policy #3-11, entitled Care and Documentation" aled, "Clinical staff evaluate be the patient at risk to terventions for the his includes, but is not eation reviews. 4. Increased ion" spital policy #3-19, entitled dated 07/02/07, revealed, employs precautionary patients who are at m, including patients who ve and/or vulnerable. dangerousness or inuous interdisciplinary	A 395			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		344002	B. WING		08	/25/2007
	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION		(X5) COMPLETION DATE
A 395	interventions that may harm prior to initiation implementation of sat but not limited to:C)Adaptations to e Precaution Level Pro Monitoring Requirem one-to-one staff keep continuous visual obsian ordered distance or risk of patient injury to Medical record review revealed the patient who was admitted on psychosis on an invo Review of the psychiatrist A upopatient had been transhospital where she with from 08/05-18/07. Review of the Fall Riscompleted on 08/19/0 patient's fall risk level Review of "Safety Pre Psychiatrist B on 08/19/0 patient's fall risk level Review of RN C's not (at time of admission revealed, "Ptalso hrisk score of 13"Review of 13	y reduce the patient's risk for a of and during the fety precautions, including onsultations (e.g., medical, environment Safety cedures and Patient ents: Strict: 1. Assigned as the patient under servation. 2. Remains within of the patient to decrease the coself and others " y on 08/23/07 of Patient #39 was a 44 year old female 08/18/07 at 2200 for acute luntary commitment order. atric assessment, made by on admission, revealed the sferred from an acute care as treated for lithium toxicity sk Assessment that was 17 (untimed) revealed the was "13at risk for falls" ecautions Order" written by 19/07 at 0108 revealed, evel: Strict (Thought d, pt [patient] physically very exit." res dated 08/19/07 at 0150 to the inpatient nursing unit) as unsteady gait c (with) fall eview of nursing 08/19/07 at 0230 revealed,	A 39	95		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		344002	B. WING		08/	25/2007
	ROVIDER OR SUPPLIER		100	ET ADDRESS, CITY, STATE, ZIP CODE 0 S STERLING ST DRGANTON, NC 28655	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
A 395	call) progress note darevealed, "Called byShe is agitated, wa on 1:1 for vulnerabilit observe patient at all Review of RN A's (m. 08/19/07 at 1205 reventire shift to present times(Psychiatrist situation at 0915. Or (milligrams) m-tab (all and Benedryl 50 mg medication) x 1 (once (medication) pass pt. antipsychotic medica out p (after) leaving medication) repatients receive med out of locked exit docand staff. Redirected to lay down s (without unoriented x 4 (disoriand situation). (Psychiatrist with the control of the	ated 08/19/07 at 1000 staff. Pt. grossly psychotic liking halls, manicShe is ly (one staff member to times)." dedication nurse) note dated lealed, "Actively hallucinating lealed, "Acti	A 395			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	344002	B. WING		08/2	25/2007
NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP		100	ET ADDRESS, CITY, STATE, ZIP CODE 0 S STERLING ST RGANTON, NC 28655		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
Review of Psychiatris call) progress note da revealed, "Pt extreme and presentlyshe is restless; walking or rufell several times that several meds - not eff from injury; will start in Geri-chair c (with) the on wrists and ankles." Review of CNA (Certi documentation dated "Pt. 1:1 this shift per within arms length dis would try to go in and trying to touch other pwalls, each time pt wo Redirection ineffective needed medication) goall. Pt would still try attempted to climb waw wall, PA notified for in attempted to run up a time-out and went in a would take back out of objects out of floor that TO door and walked in doorway. Stood in back onto floor. RN in notified a PA and other Review of CNA B's do 08/19/07 (untimed) re	ment of patient or in of treatment plan following sustained at 1030. It D's (psychiatrist 2nd on ted 08/19/07 at 1400 ly agitated the whole a.m. is 1:1 but is confused; inning away from the staff; resulted in bruises; had rective/sufficient to protect pto inedically related restraints in table top and soft restraints of the discount of other peers rooms, relations, attempting to climb bould be redirected by staff. In a count of other peers rooms, relations, attempting to climb bould be redirected by staff. In a count of other rooms and still sills. After a head hit to the jury. Pt. still climbs walls, and down halls. Pt. offered and out of time-out (TO). Pt. off TO and try to pick up at wasn't there. Pt opened in c (with) 1:1 staff standing front of wall and fell straight rootified immediately, who are proper precautions"	A 395			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	G		08/2	5/2007
	COVIDER OR SUPPLIER		•	1	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 395	voluntarily with the do of the doorway obser picking at floor. Pt. h. time-out, all shift. Stathe on-call doctor (Ps Dr. wrote order for pt. medication), pt. contil bumped head. PA with hall, running up a many attempts to red went in time-out room following. Staff heard and staff ran in to assover and assessed pt. Review of RN A's not revealed, "Patient conhallucinating p (after) per (Psychiatrist C)'s encouragement to take pace in and out of ha room, bathroom. Reform 1:1 staff. Yelling remains pressured, ra@ times. Attempted A). Flight of ideas an Walking into timeout mattress. Pt again hi on wall. Writer assess bruises noted to L for @ that time and notific c (with) 0 new orders unoriented to person, change from baseline where pt. refused lun (milliliters) of tea. (Ps 1230 c (with) report g	d walked into time-out for open. Staff stood in front wing pt. climbing walls and ad been in and out of off notified RN, who notified ychiatrist C) of pts. behavior, to have prn (as needed nued climbing walls and as notified, pt went back on and down hall, staff made irect with no success. Pt. on her on with 1:1 at hump and notified RN ist. Where RN and PA took. Vital signs were taken." The dated 08/19/07 at 1500 antinues to remain actively activan 2 mg given @ 1130 orders. (Required much are Ativan). Continues to all, rooms, day room, timeout quiring constant redirection and get imes but speech mainly apid, difficult to understand to hit 1:1 staff @ 1330 (CNA d word salad present. Froom and sat down on the L (left) inside of forehead sed forehead @ 1220. 2 ehead c (with) slight swelling ed PA. (PA A) assessed pt 0 c/o pain. Remains place, time, situation. (0 c). Assisted to dining room	A	395			

PRINTED: 12/20/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG		08/2	5/2007
	OVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
A 395	paper work started. (5 mg (Zydis) (an antip Zyprexa Zydis 5 mg groam in and out of roo bathroom. Becoming speech as above prestroom looking @ wall at (CNA A) pt. fell straig @ 1415. Both RNs (c (with) 3 CNA staff) catch pt. before fall. to ward @ 1345 to as of writing orders for mbe applied (use of Gepatient. Order given supine in floor p (afte have flight of ideas, calmost impossible to ending in a moan as swelling noted on phyhead. Moaning in ag Medical record review by PA A of an assess evaluation/modification the injury the patients. Review of a physician 08/19/07 at 0935 (and 08/19/07) revealed, "op (by mouth) x 1 nownow psychosis". Radministration record m-tab 2mg and Beneby mouth at 1000.	prize tracted c (with) appropriate orders given to give Zyprexa psychotic medication) x 1. given @ 1310. Continued to pm, hallway, timeout room, a louder c (with) same sent. Walked into timeout and according to 1:1 staff, the back hitting head on floor writer and [RN B]) into room a1:1 staff reports unable to Prior to fall, (Psychiatrist D) seess pt. and was in middle nedical related restraints to eri-Chair) for safety of @ 1400. Patient laying r) fall @ 1405 continuing to (with) word salad becoming understand verbally. Words if in pain. Large amount of vsical examination to back of ony upon touch"	A	395			

Facility ID: 956125

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		344002	B. WING	3		08/2	5/2007
	COVIDER OR SUPPLIER			1000	T ADDRESS, CITY, STATE, ZIP CODE O S STERLING ST RGANTON, NC 28655	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTI		ULD BE	(X5) COMPLETION DATE
A 395	hr (hour) c (with) resumant MAR revealed Ativariand 1130. Review of a physician Psychiatrist C) dated "Give Zyprexa Zydis psychosis." Review Zyprexa Zydis 5 mg was 2 mg years a Zydis 6 mg years a Zydis 7 mg years a Z	o x 1 now. Call Dr. back in 1 ults of PRN." Review of the 12 mg was given by mouth at n's telephone order (given by 08/19/07 at 1300 revealed, 5 mg PO x 1 now - of the MAR revealed was given by mouth at 1310. 2/2007 at 1620 of the timeout m with concrete walls and an or. on 08/23/07 at 0900 revealed uty at 0700 on 08/19/07 and nurse for the day on the unit. the nurse knew Patient #39 in strict observation for Interview revealed the patient had been identified dmission. Interview revealed signed to the patient was in 1:1 observation and keep	A	395			

CLIVIER	O I OR WILDICARE &	WEDICAID SERVICES				- CIVID INC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	1G		00/0	F/0007
NAME OF DE	AOVIDED OD OUDDUIED	344002		Г		08/2	5/2007
NAME OF PR	OVIDER OR SUPPLIER			ı	REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST		
BROUGH	TON HOSP			ı	MORGANTON, NC 28655		
	OLIMANA DV. OT	ATEMENT OF REFIGIENOIS				FIGN	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETION	
A 395	Continued From page	e 60	Α	395			
	revealed the patient v	was constantly pacing and					
	walking in the hall an	d tried to enter any open					
	room. Interview reve	aled the 1:1 staff continually					
	walked with the patie	nt in the hall and had to					
		equently. Interview revealed					
	·	in and out of the time-out					
		Interview revealed the					
		e same as the seclusion					
		aled the timeout room had					
		floors that was used as a n to isolate a patient from					
		ure the safety of all patients					
	-	bursts. Interview revealed					
	_	placed in the timeout room					
		ention, but rather the patient					
		nd out of the room. Interview					
	revealed Psychiatrist	C was on the unit and saw					
		mately 0900. Interview					
		00 the nurse discovered the					
	-	owed the morning dose of					
		hotic medication that had					
		Interview revealed the					
		trist C at approximately 1000					
		behavior of "pacing the he walls, poor articulation,					
		word salad" and the fact that					
		wallowed her Seroquil.					
	Interview revealed Ps	•					
		enedryl 50 mg to be given					
		gave at 1000. Interview					
		wandered into the timeout					
		ch time she tried to sit on the					
		the floor and bumped her					
	_	inch laceration on her right					
		evealed PA A was on the					
		nd he "came and looked at					
		view revealed a Band-Aid					
		ceration and no new orders					
	were received. Inter\	view revealed the patient					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		344002	B. WIN	IG	 	08/2	5/2007
	ROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD IT AG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		LD BE	(X5) COMPLETION DATE	
A 395	patient was in and ou Interview revealed the one place for more the time and continued to Interview revealed the remained unchanged Psychiatrist C of this Ativan 2mg was orde Interview revealed Psychiatrist C of this Ativan 2mg was orde Interview revealed Psychiatrist again wan and "bumped her head bruises to her left for PA A assessed the psecond "bump" and not changed, at which ordered and given to revealed the Zyprexa "slow her downto so Interview revealed Zydrowsiness and "kick based on what I've se "We were keeping and revealed Psychiatrist patient. Interview revealed Psychiatrist with a Geri-chair with legs at 1400, after see the hall with the assist Interview revealed that is often used on the house supervisor revealed that at 1405,	d walk the halls, often two, CNAs and the at of the timeout room. The patient wouldn't stay in any man a few seconds at the phave an unsteady gait. The patient's behavior and the nurse notified fact at 1130, at which time ared and given to the patient. Sychiatrist C did not come anterview revealed at 1230 andered into the timeout room and on the wall, resulting in 2 schead. Interview revealed attent immediately after the monew orders were received. The nurse called Psychiatrist C and the patient. Interview was given in an effort to stop the psychosis. The prexa commonly causes in in about 30-45 minutes, seen." Interview revealed, a eye on her." Interview C did not come assess the realed Psychiatrist D came oximately 1345. Interview D ordered medical restraints soft restraints to arms and eing the patient walking in	A	395			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	G		08/2	5/2007
	ROVIDER OR SUPPLIER		'	10	EET ADDRESS, CITY, STATE, ZIP CODE 100 S STERLING ST ORGANTON, NC 28655		5/ 2 001
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 395	Psychiatrist attended subsequently transfer hospital's emergency CNA A was unavailable. Interview with CNA B revealed CNA A was to Patient #39 on the both CNAs worked w revealed they "split the we both worked with CNA knew the patient length at all times. In knew the patient had risk for a fall and the sprevent a fall. Interview "very unsteady when revealed the patient wher room and the batt unsteady". Interview was "real wobblyit overstepping her step the wallslooked like steps". Interview revecence to assist the patient wher clothes down". In point (unsure of exact the timeout room and at which time CNA A the wall." Interview reported to the nurses two CNAs and PA A to treatment room to cle bumped her head in trevealed the patient was the control of the patient was the patient of the patient was the patient of the patient o	ealed the nurse, PA and to the patient, who was red to an acute care department via EMS. Die for interview. On 08/23/07 at 0950 the primary CNA assigned morning of 08/19/07 but ith the patient. Interview re 1:1, but most of the day her". Interview revealed the t should be within arms terview revealed the CNA been identified as being at staff were to try to help rew revealed the patient was she walked". Interview was constantly in and out of proom and was "still very revealed the patient's gait was like she was resulted in took both of the patient use the bathroom thold her up for her to get atterview revealed at one to time) the patient went in to CNA A was "watching her" called out, "She walked into revealed "all of this was still not the patient to the	A:	395			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG		08/2	5/2007
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE	
A 395	Band-Aid on her eyet the PA asked the CN why the patient's spe she was so unsteady behavior went on all of the patient was "very and both CNAs (one walked with her continall. Interview reveal timeout room (unsure standing in the doorw (patient) was standing to come toward us. A turned and bumped in on her forehead". Interview revealed, "I've never the timeout room with voluntarily. My under length is if they are not interview revealed the PA came the patient's head and be a bruise and bump patient continued to will net view revealed the patient was safe becaused the patient was safe becaused to (RN A) we (RN A) called the psy a CNA stayed on each she walked in the halfrom bumping into stuff elbow when she woul revealed at one point redirect the patient from the	A if it had been determined ech was so slurred and why . Interview revealed "this day long". Interview revealed unsteady walking in the hall" on each side of the patient) muously when she was in the ed the patient went into the e of time) and "we were vay looking at her. She g at the window and turned as she was coming she not the wall and got a knot erview revealed the distance se doorway is more than mately 8 feet). Interview been told you have to be in a patient if they are in there estanding of the strict arms of in the timeout room." e CNAs notified the nurse umped her head. Interview e and looked at the bump on d said "you can see this will o". Interview revealed the valk and pace in the halls. The cNA did not feel like the eause "she was still bumping us watching herWe have to do something. Interview revealed the side of the patient while I in an effort to "keep her uffI would support her	A	395			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING _		08/2	5/2007
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 395	staff member she was so she wouldn't fall". patient again went int A "stood in the door verealed, "I was takin room door and I hear (patient) was on the finurse, PA and Psych patient, who was sub acute care hospital's EMS. Interview with PA A of the PA was on the un 08/19/07 because he physical assessments patients, including Parevealed the PA obse "with two CNAs with I revealed the patient's with a jumpy kind of vigatient would "miss a would have to regain revealed the PA was (unsure of time) wher (patient) hit her head left eyebrowI looke on it." Interview revealed into the wall did not adjust the treat notify his supervising condition. Interview relater "the nurse told nagain and I went to that her head". Interview forehead was "maybe forehead was "maybe forehead".	nen the patient swung at the sunsteady so they "held her Interview revealed the o the timeout room and CNA watching her". Interview g the trash past the timeout d 'Boom'. I looked and she loor". Interview revealed the fatrist attended to the sequently transferred to an emergency department via n 08/23/07 at 1100 revealed it on the morning of had to do admission so n several newly admitted	A 398	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/2	5/2007
	ROVIDER OR SUPPLIER		10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST IORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 395	Interview revealed the while until the nurse of time) and said "come revealed the nurse rebackwards and hit he timeout room. Interview same time. Interview the patient until EMS patient to an acute cadepartment. Interview psychiatrist can order Interview revealed the nursing staff to call the head bumps. Telephone interview o8/23/07 at 1115 revebeen on staff at the head bumps. Telephone interview revealed the primary on call psychological of the psychiatrist time) that Patient #39 morning dose of Sercivery agitated and was behavior. Interview revealed the to hour and a half late still very agitated and Interview revealed the Benedryl to be given sometimes Risperdal be given at the same but the psychiatrist di	that time or notify his of the patient's condition. The PA then left the unit for a called him back (unsure of right away". Interview port the patient had fallen or head on the floor in the ew revealed the PA and to the timeout room at the revealed they attended to arrived and transported the are hospital's emergency or revealed only a "restrictive measures". The PA had not requested the epsychiatrist after either of with Psychiatrist after either of expectation with Psychiatrist C on ealed the psychiatrist had ospital for one week. The psychiatrist was the expectation the hospital on evealed the nurse had st in the morning (unsure of thad not swallowed her or optical and the patient was	A 395			

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				- OIVID INC	<u>, 0930-039 i</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG		08/2	5/2007
	OVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE		
				_ n	MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
A 395	the patient was still verawling on the floor. nurse then said the properties in the timeor head on the wall. Into said something like shead." Interview reverto the incident was "putripped and bumped herevealed the nurse dinad an unsteady gait psychiatrist was awar patient after the bump should have called his an internist. Intervity psychiatrist ordered for Ativan. Interview revealed the nurse dinad an unsteady gait psychiatrist ordered for Ativan. Interview revealed the psychiatrist ordered for Ativan. Interview revealed they kept using. Interview for their conversation. In Psychiatrist D - 2nd what else we could give revealed the psychiatrist knew going to be making round them say they women's ward". Interview revealed them say they women's ward". Interpsychiatrist went to the and the patient was latereatment room. Interview material to the said the patient was latereatment room. Interview the said the patient was latereatment room. Interview revealed the patient was latereatment room. Interview revealed them say they women's ward". Interview revealed them say they women's ward. Interview revealed the psychiatrist went to the and the patient was lateratment room. Interview revealed the psychiatrist went to the revealed them.	en nurse called the put one hour later and said ery agitated and was Interview revealed the atient had laid on the ut room and bumped her erview revealed the "nurse he had stumbled and hit her ealed the information related tresented more like she her head". Interview d not report that the patient Interview revealed the ethe PA had seen the end and if he had concerns he is supervising physician, who ew revealed at that time the end and said the patient was around agitated with the 1:1 up and down the hall with ed "agitated was the word erview revealed, "I called on call that day) to discussive her (patient)". Interview rist then ordered for the express. Interview revealed the unit soon after another unit when she want a PA right now on the eview revealed the ne women's ward at that time aying on the floor in the rview revealed "we	A	395			
	assessed her and ser	nt her to the hospital".					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE &	VIEDICAID SERVICES				OMP INC	<u> </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	344002	B. WIN	IG		08/2	5/2007
NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP			10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST IORGANTON, NC 28655	00/2	0/2001
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
call psychiatrist on 08 making rounds on the Psychiatrist C had cal morning (unsure of tir #39 with her. Intervie the level of the patien medication plans for trevealed she told her monitoring for vulnera fallen" but didn't say verification plans for trevealed she told her monitoring for vulnera fallen" but didn't say verification patient, but rather that would be making rour Interview revealed nuther of the patient's conducted because they were conducted by the patient had an unsurevealed, "When I say the only way to prevert in the Geri-chair." the Geri-chair with sort to protect the patient. It is psychiatrist saw the patient waiting to knew it they were an accident waiting to knew it they were an revealed the patient for could execute the ord Interview revealed that unusual on a psychiatric used there and are so Interview revealed an for a patient with acut	with Psychiatrist D on ealed she was the 2nd on 1/19/07 and was therefore a units. Interview revealed lled her at some point that me) and discussed Patient aw revealed they discussed it's agitation and possible treatment. Interview the patient was on 1:1 ability and had "already why. Interview revealed that ask her to go see the it she knew Psychiatrist D ands on the unit soon anyway. In the ise is a say that is a say the patient walking in embers." Interview revealed steady gait. Interview revealed steady gait. Interview what was going on I said inther from falling was to put Interview revealed after the satient, she thought "it was in happenthey (the staff) ware of it". Interview ell before the nursing staff ler for medical restraints are tric unit, but they can be	A	395			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/2	5/2007
	OVIDER OR SUPPLIER		10	EET ADDRESS, CITY, STATE, ZIP CODE 100 S STERLING ST ORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 395	medication or someth PA with concerns abore his supervising physic psychiatrist for guidar Interview with adminition 108/24/07 at 1530 reversions present at the time of administrator at home Serious Incident Notifies the house supervisor investigation into the the investigation inclurecord and related incinterviews. Interview Analysis had been in the administrator of the manager (both presecare and monitoring pos/19/07 had been aprevaled after review during the internal investigation in concelled 911 directly, rathospital's procedure coperator. Interview rethought that the patie appropriately adjusted maintained 1:1 monitiphysician for medicate the shift on which the Consequently, there is nursing, medical and year old female patie gait. As a result, the	ess they have too much hing". Interview revealed a put a patient could contact cian (an internist) or the nee. strative nursing staff on ealed the nursing staff if the fall had notified the earlier in had been done by which prompted an internal incident. Interview revealed added a review of the medical cident report, as well as staff revealed no Root Cause it interview revealed ne division and the nurse not at interview) both felt the provided for the patient on oppropriate. Interview ing the information obtained vestigation, including the diministrator and nurse tern was that the nurse had other than following the of calling the in house evealed the nurse manager not's treatment plan was discovered by the policy of the information obtained of calling the in house evealed the nurse manager not's treatment plan was discovered by the policy of the patient of calling the inhouse evealed the nurse manager not's treatment plan was discovered by the policy of the patient	A 395			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING			
NAME OF PF	ROVIDER OR SUPPLIER	344002	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	•	25/2007
BROUGH	TON HOSP		100	0 S STERLING ST RGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 395	the patient to be transhospital for emergence B) Review of the hos and Plan of Care" pol 2007 reveals "The Retime of admission, as immediate needs rela admission and currendevelops a plan to meassessment process patient's hospitalization patient's physical, psysocial, nutritional, economical, nutritional, economical	sferred to an acute care by treatment. pital's "Nursing Assessment icy effective February 26, agistered Nurse (RN), at the sesses the patient's sted to the reason for at health status, and seet those needs. The continues throughout the fon. The nurse evaluates the cychological, educational, anomic and spiritual needs to a rursing careOngoing the umented in the progress sment forms as the patient's stated in the receiving facility there are difficulties or the receiving facility, this is redical record. If it is an to transport by EMS (a), and inform the receiving facility the end of the receiving facility the end of the receiving facility the receiving the receiving facility there are difficulties or the receiving facility the receiving the to contact the receiving facility the facility the receiving facility t	A 395			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/2	5/2007
	ROVIDER OR SUPPLIER		10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST IORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 395	(Send one copy to the the original in the mischart)." Closed record review revealed a 41 year-ol 07/26/2007 with majo 07/30/2007. Record was transferred from C) emergency depart attempt. Review of revealed a pregnancy negative. Review of physical exam dictate patient's "LMP (last merses and her physical exam dictate patient's "LMP (last merses and her physical exam dictate patient's "LMP (last merses and her physical exam dictate patient's "LMP (last merses and her physical exam dictate patient's "LMP (last merses and her physical exam dictate patient's "LMP (last merses and her physical exam dictate patient and came out requested blood running dostated 'I think I had a reports a history of mevaluated by PA (Physicalled EMS (emerger transported to (acute record revealed the merses and the patient's vital signs docum reported the bleeding assessment of the anof bleeding, assessment of the anof bleeding, assessment or level of conscious record revealed no plus the patient and no do	mmary/Consult Referral e receiving facilityand file cellaneous section of the on 08/23/2007 of Patient #4 d female that was admitted or depression and discharged review revealed the patient an acute hospital (Hospital ment (ED) due to a suicide ecords from Hospital C's ED or test dated 07/25/2007 was the physician's history and ed 07/28/2007 revealed the enestrual period): patient has beriods are irregular." es dated 07/29/2007 at 1225 was in restroom this AM ting help. Patient had bright with both inner thighs. Patient miscarriages. Patient visician's Assistant). PA ney transport). EMS Hospital B)." Review of the eext nursing entry was 2/2007 at 2020. Review of eet revealed documentation igns at 0800 and 2000. revealed no assessment of ented when the patient and no documented mount of blood loss, duration ent of last menstrual period ness. Further review of the mysician's order to transfer	A 395			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		UCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING	§		08/2	5/2007
	COVIDER OR SUPPLIER		'	1000 S STER	SS, CITY, STATE, ZIP CODE LLING ST ON, NC 28655		
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A 395	transferred or returned documentation of the return from the acute department. Review of the transferemergency department #4 arrived via EMS or chief complaint of "spincreased vaginal ble pregnancy test on 07, revealed the patient of "certified nursing assisted and a pelvic exam were emergency department of "dysmennorhea" and discharged. Further in reveal a time of discharged (PA B) revealed a time of discharged (PA B) revealed the patient of "dysmennorhea" and discharged (PA B) reveal a time of discharged (PA B) reveal a time of discharged (PA B) revealed the bathroom stall. Bnot poolingsanital said it had just started her. She was afraid, was having a miscarrexam at that time. If the urgently. There was feel she needed to be in an emergency roor referral to specialty secall EMSI don't retarnsfer paperwork. I	at time the patient was d to the hospital, and no patient's condition upon care hospital's emergency rring hospital's (Hospital B) nt record revealed Patient n 07/29/2007 at 1107 with a otting times four days, eding today, negative /25/2007." The record was accompanied by a CNA stant). Record review blood pressures, lab studies ere completed in the nt. Review of the ED tation revealed a diagnosis and the patient was review of the record failed to	A:	395			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL- IDENTIFICATION NUMBER: A. BUILDI		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		344002	B. WING	<u> </u>	08/:	25/2007	
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1000 S STERLING ST MORGANTON, NC 28655	-	2072007	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A 395	did not document that For the past year, we relationship with (Hoswon't talk with us. The take the patients back to call them." Interview on 08/24/20 was working on 07/29 transferred (RN D) repatient. The nurse stake was having a mis "bright red blood runnurse stated that ther and described the amnurse stated he notification. The interview for emergency transpethat the PA usually compaperwork. The nurse Hospital B's ED to give required transfer paper The nurse reviewed to the bleeding was reported to the patient's condition return to the hospital 482.23(b)(4) NURSINTER The nurse reviewed to the hospital 482.23(b)(4) NURSINTER The hospital must entered to call the patient's condition return to the hospital 482.23(b)(4) NURSINTER The hospital must entered to call the patient's condition return to the hospital the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition return to the hospital must entered the patient's condition the patient's	I did call the ED nurse. It I called the ED nurse don't have a good spital B ED). The physicians sey are worried that we won't k. It is a waste of time trying and the spital B ED a	A 3				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		344002	B. WING	3		08/2	5/2007
	OVIDER OR SUPPLIER		·	100	ET ADDRESS, CITY, STATE, ZIP CODE 10 S STERLING ST DRGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ACTION SHOULD BE FO THE APPROPRIATE	
A 396	Continued From page	e 73	Α:	396			
	Based on hospital por reviews, observations interviews the hospital update the nursing carepeated injuries relationship.	not met as evidenced by: blicy review, medical record s and staff and physician al's nursing staff failed to are plan of a patient with atted to a known unsteady gait attents with an unsteady gait					
	"Nursing Assessmen 02/26/07, revealed, "assesses the patient to the reason for adm status, and develops The assessment proof the patient's hospitalithe patient's physical plan for nursing care interventions into the planPatient problem (s) which hospitalized initially chospitalized initially chospitalized in the nursing care included in the nursing included in the nursing inficantlyand/or treatment intervention monitoringare also plan of care. When researce to the patient	ed to the impaired safety of) the primary problem(s) and ursing plan of care. t the patient's lifestyle					
	addressed in the nurs	sing plan of care re writtenIndividualized are based upon the data					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/	25/2007
	COVIDER OR SUPPLIER		1000	T ADDRESS, CITY, STATE, ZIP CODI O S STERLING ST RGANTON, NC 28655	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
A 396	needed and include resuccess at meeting of provided, and assess documented in regular treatment/progress in Nursing Plan of Care plan of care is updated identified The RN is summarizing the protopatient's response to problem status" Medical record review revealed the patient who was admitted on psychosis on an invoice Review of the psychiatrist A uppatient had been transpital where she we from 08/05-18/07. Review of the Fall Riscompleted on 08/19/0 patient's fall risk leveral revealed the patient of the psychiatrist B on 08/19/0 patient's fall risk leveral revealed, "Safety Precaution Leprocesses fragmented frail, very unsteady greated and revealed, "Ptalso brisk score of 13"	addated and changed as ationale, frequency, sponsibilityThe patient's bjectives, the nursing care are are are are are atnursing of the second of th	A 396			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	G		08/2	5/2007
	COVIDER OR SUPPLIER		•	10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST ORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 396	a nursing care plan e dated 08/19/07 (untin C, the nurse that adm during the third shift or revealed the nursing updated since this ad Review of Psychiatris call) progress note darevealed, "Called by s She is agitated, wal on 1:1 for vulnerability observe patient at all Review of RN A's (mo 08/19/07 at 1205 reveentire shift to present times (Psychiatrist situation at 0915. Or (milligrams) m-tab (an and Benedryl 50 mg (medication) x 1 (once (medication) pass pt. antipsychotic medication out p (after) leaving medication to locked exit doo and staff. Redirected to lay down s (without unoriented x 4 (disoriand situation). (Psyc (with) orders to give A and call back in 1 houstumbled into wall r/t and untied shoe string	v revealed documentation of ntitled "At Risk for Falls" ned) that was initiated by RN nitted the patient to the unit of 08/18/07. Record review care plan had not been mission care plan. It C's (primary psychiatrist on ated 08/19/07 at 1000 staff. Pt. grossly psychotic king halls, manicShe is y (one staff member to times)." Redication nurse) note dated ealed, "Actively hallucinating . Pacing halls, running at C) paged and notified of ders to give Risperdal 2 mg in antipsychotic medication) (an antihistamine e). Prior to this, @ 0800 med put Seroquel (an tion) in mouthand spit it ned line (place where cation). Attempting to walk rs. Touching other patients to time-out and encouraged the success. Remains ented to person, place, time thiatrist C) contacted again c Ativan 2 mg (given @ 1130);	A	396			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/	25/2007
	OVIDER OR SUPPLIER		1000	T ADDRESS, CITY, STATE, ZIP CODE OS STERLING ST RGANTON, NC 28655	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 396	inch laceration. PA ((PA A) who assessed given. Pupils reactive c/o (complaints of) pa Remains unoriented baseline). Will continuo f Ativan." Medical record review by PA A of an assesse evaluation/modification the injury the patient. Review of Psychiatris call) progress note darevealed, "Pt extreme and presentlyshe is restless; walking or refell several times that several meds - not effrom injury; will start of Geri-chair c (with) the on wrists and ankles. Review of CNA (Cert documentation dated "Pt. 1:1 this shift per within arms length dis would try to go in and trying to touch other walls, each time pt we Redirection ineffective needed medication) call. Pt would still try attempted to climb with wall, PA notified for in attempted to run up a still try attempted to run up a sti	physician's assistant) notified of pt c (with) no new orders to light and equal. 0 (no) ain, 0 swelling, bruising. At 4 (0 change from the to monitor effectiveness of the vertical part of the patient or on of treatment plan following sustained at 1030. At D's (psychiatrist 2nd on ated 08/19/07 at 1400 aly agitated the whole a.m. as 1:1 but is confused; unning away from the staff; a resulted in bruises; had fective/sufficient to protect pt medically related restraints in a table top and soft restraints	A 396			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	G		08/2	5/2007
	ROVIDER OR SUPPLIER		•	10	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
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A 396	would take back out of objects out of floor that TO door and walked in doorway. Stood in back onto floor. RN r notified a PA and other Review of CNA B's do 08/19/07 (untimed) revulnerable for harm, he behavior this shift, ha voluntarily with the dof the doorway obserpicking at floor. Pt. htme-out, all shift. Stathe on-call doctor (Ps Dr. wrote order for pt. medication), pt. continumped head. PA wathe hall, running up an many attempts to redwent in time-out room following. Staff heard and staff ran in to assover and assessed pt. Review of RN A's not revealed, "Patient cohallucinating p (after) per (Psychiatrist C)'s encouragement to take pace in and out of hall room, bathroom. Recform 1:1 staff. Yelling remains pressured, ra@ times. Attempted A). Flight of ideas an Walking into timeout in the control of the pace in and out to the pace in the pace in the pace in and out of hall room, bathroom. Recform 1:1 staff. Yelling remains pressured, ra@ times. Attempted A). Flight of ideas an Walking into timeout in the pace in and out to the pace in and out of the pace in a	of TO and try to pick up at wasn't there. Pt opened on c (with) 1:1 staff standing front of wall and fell straight notified immediately, who are proper precautions" Documentation dated evealed, "Pt strict for nad been exhibiting bizarre d walked into time-out nor open. Staff stood in front wing pt. climbing walls and ad been in and out of aff notified RN, who notified eychiatrist C) of pts. behavior, to have prn (as needed nued climbing walls and as notified, pt went back on and down hall, staff made irect with no success. Pt.	A	396			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING _		08/2	5/2007
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 396	bruises noted to L for @ that time and notific (with) 0 new orders unoriented to person, change from baseline where pt. refused lun (milliliters) of tea. (Ps 1230 c (with) report g fact that pt. unsteady that PA had been corpaper work started. (5 mg (Zydis) (an antig Zyprexa Zydis 5 mg g roam in and out of roobathroom. Becoming speech as above preroom looking @ wall. (CNA A) pt. fell straig @ 1415. Both RNs (c (with) 3 CNA staff) catch pt. before fall. to ward @ 1345 to as of writing orders for m be applied (use of Gepatient. Order given supine in floor p (afte have flight of ideas, calmost impossible to ending in a moan as swelling noted on phyhead. Moaning in ag Medical record review by PA A of an assess evaluation/modification the injury the patient.	ehead c (with) slight swelling ed PA. (PA A) assessed pt of color of pain. Remains place, time, situation. (0 et). Assisted to dining room the and drank 20 cc sychiatrist C) contacted @ iven of situation including gait, stumbling, hit head and stacted c (with) appropriate Orders given to give Zyprexa psychotic medication) x 1. given @ 1310. Continued to pom, hallway, timeout room, a louder c (with) same sent. Walked into timeout and according to 1:1 staff, the back hitting head on floor writer and [RN B]) into room in a1:1 staff reports unable to Prior to fall, (Psychiatrist D) issess pt. and was in middle nedical related restraints to en-i-Chair) for safety of @ 1400. Patient laying r) fall @ 1405 continuing to (with) word salad becoming understand verbally. Words of in pain. Large amount of visical examination to back of cony upon touch"	A 396			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG		08/2	5/2007
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 396	Interview with RN A of the nurse came on downs the medication in Interview revealed the was ordered to be on vulnerability to harm. nurse was aware the as a falls risk upon actine CNA (CNA A) assinstructed to maintain the patient within arm Interview revealed the not designated the disorders, the nursing st strictest, which is with Interview revealed the Patient #39 at approximate the patient's gait was later in the morning. patient's gait was unsobserved the patient "unsteady gait puts a Interview revealed "th' (patient's) elbow to surevealed the patient walking in the hall and room. Interview revewalked with the patient from several times. It imeout room was the room. Interview revewalded walls and frestrictive intervention.	on 08/23/07 at 0900 revealed outy at 0700 on 08/19/07 and ourse for the day on the unit. The nurse knew Patient #39 strict observation for Interview revealed the patient had been identified dmission. Interview revealed signed to the patient was a 1:1 observation and keep as reach at all times. The at since the physician had stance of observation on the aff "always assumes the nin arms length at all times".	A	396			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR NC). 0 <u>938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF	
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A 396	Continued From page	e 80	A	396			
	during behavioral out	bursts. Interview revealed					
	_	placed in the timeout room					
		ention, but rather the patient					
	freely wandered in ar	nd out of the room. Interview					
	revealed Psychiatrist	C was on the unit and saw					
	the patient at approxi	mately 0900. Interview					
		00 the nurse discovered the					
	I -	owed the morning dose of					
		hotic medication that had					
	,	Interview revealed the					
		trist C at approximately 1000					
		behavior of "pacing the					
		the walls, poor articulation, word salad" and the fact that					
		wallowed her Seroquil.					
	Interview revealed Ps	-					
		enedryl 50 mg to be given					
		e gave at 1000. Interview					
		wandered into the timeout					
	•	ch time she tried to sit on the					
		the floor and bumped her					
		inch laceration on her right					
	eyebrow. Interview re	evealed PA A was on the					
	unit making rounds a	nd he "came and looked at					
		view revealed a Band-Aid					
	was applied to the lad	ceration and no new orders					
		view revealed the nursing					
		changed. Interview revealed					
		to pace and walk the halls					
		, often two, CNAs and the					
	·	it of the timeout room.					
		e patient wouldn't stay in any					
	•	nan a few seconds at the					
		have an unsteady gait.					
	Interview revealed the	e patient's behavior I and the nurse notified					
	_	fact at 1130, at which time					
		red and given to the patient.					
		sychiatrist C did not come					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG		08/2	5/2007
	OVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
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A 396	the patient again wan and "bumped her hea bruises to her left fore PA A assessed the pasecond "bump" and not changed. Interview revealed the not changed. Interview Psychiatrist C again a behavior had not changed was ordered and Interview revealed the effort to "slow her down Interview revealed Zydrowsiness and "kick based on what I've se "We were keeping an revealed Psychiatrist patient. Interview revealed Psychiatrist D came to approximately 1345. Psychiatrist D ordered Geri-chair with soft reduced the Geri-chair with soft reduced the Geri-chair with soft reduced the Geri-chair with soft revealed the Geri-chair with soft revealed that at 1405 the Geri-chair, the paroom". Interview revealed subsequently transfer hospital's emergency Interview confirmed the second in the secon	anterview revealed at 1230 andered into the timeout room and on the wall, resulting in 2 and and interview revealed attent immediately after the so new orders were received. The analysis are revealed the nurse called at 1310 to report the patient's anged, at which time Zyprexa and given to the patient. The Zyprexa was given in an analysis and in about 30-45 minutes, are in in about 30-45 minutes, are in in about 30-45 minutes, are on her." Interview as sent and interview revealed and to the unit at a linterview revealed and medical restraints with a distraints to arms and legs at a patient walking in the hall of two CNAs. Interview air is not something that is a to, so the nurse called the coate one. Interview tealed the nurse could get tient "fell in the timeout tealed the nurse, PA and to the patient, who was	A	396			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG_		08/2	5/2007
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A 396	CNA A was unavailable. Interview with CNA B revealed CNA A was to Patient #39 on the both CNAs worked w revealed they "split the we both worked with CNA knew the patient length at all times. In knew the patient had risk for a fall and the sprevent a fall. Interview "very unsteady when revealed the patient wher room and the batt unsteady". Interview was "real wobblyit overstepping her step the wallslooked like steps". Interview revealed they had to her clothes down". In point (unsure of exact the timeout room and at which time CNA A the wall." Interview reported to the nurses two CNAs and PA A treatment room to cle bumped her head in the revealed the patient we treatment room but the Band-Aid on her eyet the PA asked the CN why the patient's spesshe was so unsteady	on 08/23/07 at 0950 the primary CNA assigned morning of 08/19/07 but ith the patient. Interview he 1:1, but most of the day her". Interview revealed the t should be within arms terview revealed the CNA been identified as being at staff were to try to help hew revealed the patient was she walked". Interview has constantly in and out of hroom and was "still very herevealed the patient's gait has like she was he was bumping into he she was trying to walk up healed it took both of the hatient use the bathroom hold her up for her to get hereview revealed at one he time) the patient went in to he CNA A was "watching her" hold called out, "She walked into hevealed "all of this was he cook the patient to the	A	396			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 396	and both CNAs (one walked with her continued to come toward us. A turned and bumped in on her forehead". Interview revealed, "I've never the timeout room with voluntarily. My under length is if they are not interview revealed the that the patient had be a bruise and bumpatient continued to voluntarily with two of uncertifications and be a bruise and bumpatient continued to voluntarily with two of uncertifications and be a bruise and bumpatient was safe becaused the PA came the patient was safe becaused the patient was safe becaused the patient was safe becaused to (RN A) we (RN A) called the pay a CNA stayed on each walked in the halfrom bumping into stuelbow when she would revealed at one point redirect the patient swull interview revealed who staff member she was so she wouldn't fall". patient again went into the patient again aga	unsteady walking in the hall" on each side of the patient) nuously when she was in the ed the patient went into the of time) and "we were ray looking at her. She g at the window and turned as she was coming she nto the wall and got a knot erview revealed the distance e doorway is more than mately 8 feet). Interview been told you have to be in a patient if they are in there estanding of the strict arms of in the timeout room." e CNAs notified the nurse umped her head. Interview e and looked at the bump on d said "you can see this will o". Interview revealed the valk and pace in the halls. e CNA did not feel like the ause "she was still bumping as watching herWe have to do something. chiatrist". Interview revealed h side of the patient while l in an effort to "keep her offI would support her	A	396			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTI LDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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A 404	room door and I hear (patient) was on the finurse, PA and Psych patient, who was sub acute care hospital's EMS. Interview reve informed the CNA of during the shift. Consequently, nursin psychiatric physician physical and behavior #39, 44 year old patient #39. As a reinjuries on 08/19/07, subsequently requirin hospital for emergent 482.23(c) ADMINIST Drugs and biologicals administered in acco State laws, the order practitioners respons	ng the trash past the timeout rd 'Boom'. I looked and she floor". Interview revealed the niatrist attended to the osequently transferred to an emergency department via aled the RN had not a different plan of care ong services, medical and sefailed to coordinate the oral care needs of Patient ent with a diagnosis of an unsteady gait. Facility staff supervise the wandering of esult, Patient #39 sustained 3 at 1030, 1230 and 1405, and transfer to an acute care cy treatment. FRATION OF DRUGS Is must be prepared and rdance with Federal and so of the practitioner or sible for the patient's care as 2.12(c), and accepted		404			
	Based on policy and medical record review	not met as evidenced by: procedure review, open w and staff interviews the o follow the physician's order					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/2	5/2007
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
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A 404	pressure prior to 45 chypotensive medication records (#45). The findings include: Review of the policy dated 02/2005 reveal pertinent information alter the routine methodication/treatment. Medical record review patient #45 was admidiagnosis of paranoic hypertension and reneview of a physician 1635 revealed "Start lower the blood press (per mouth) BID (twice "MEDICAL ALERT - (Systolic < 110 Diastothe Medication Asses 06/2007 and 07/2007 documented with the review revealed their the 56 times to obtain prior to administering the month of June. Finurse held the Ateno 06/10/2007 due to a review revealed admivithout documentation Review of the MAR donursing staff failed to pulse prior to administed oses for the 19 days	obtain the patient's blood of 91 administrations of a on for 1 of 21 sampled open "Medication Administration" ed "Medical Alert: any about the patient that would od of administration of ." v on 08/24/2007 revealed itted to the hospital with the	A 404			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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A 468	supervisor confirmed the nursing staff to for monitor the blood pre administering Atenolo confirmed the nursing Medical Alert 45 time Atenolol to patient #4 482.24(c)(2)(vii) CON DISCHARGE SUMM	administration on 207 at 1300 with the nursing the physician had ordered allow the Medical Alert to essure and pulse before pol. Further interview g staff had failed to follow the esprior to administration of esprior to esprior to administration of esprior to		468			
	Based on policy and interview, physician i review, the hospitals failed to ensure dischauthenticated /co-autindividual(s) respons	ible for 4 of 4 discharge , completed by Physician T and 51).					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		0.8	/25/2007
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A 468	"Discharge Summary (Dictated) No later the Review of the hospital dated 05/25/2007 review record are dated and the medical record the medical practition him/her." Interview on 08/24/20 Information Manager hospital has had an irecords since Decemination of the services of a Locassist in "catching uphaving the physician discharge summaries Physician T was not the patients care during the patients care during the physician of the patients care during the physician of the patients care during the patients care during the physician of the patients care during the patients care during the physician of the patients care during the physician of the patients care during the patients of the patient	dated 05/25/2007, revealed No later than 15 Days an 30 Days (Complete)". Al's "Medical Records" policy vealed, "Entries in the patient authenticated The parts of that are the responsibility of the are authenticated by DO7 at 1340 with the Health ment Manager revealed the increase in delinquent the 2006. The interview the hospital started to use the physician to or on delinquent records by complete delinquent s. The interview revealed the physician responsible for ing the hospitalization for the discharge summaries. The interview revealed the physician responsible for the discharge summaries. The day of the credential file for the one of the credential file for the order of the credential file for	A 468			

NAME OF PROVIDER OR SUPPLIER BROUGHTON HOSP B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PREFIX	(EACH DEFICIENC	ENCY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
A 488 Summaries, and given examples of previous discharge summaries. The interview revealed Physician T has not been involved in the patient care of the patients whose discharge summaries he has dictated. The interview revealed there is not a process in place to have the physician responsible for the patients' treatment to review the discharge summary and co-authenticate the entry to verify content. Record review on 08/25/2007 revealed patient # 50 discharged from the hospital on 02/09/2007 (4 months prior to Physician T's appointment). Review of the discharge summary revealed Physician T dictated the discharge summary on 07/16/2007 (5 months after the patients discharge). Review of the discharge summary failed to reveal authentication by Physician T. Record review on 08/25/2007 revealed patient # 49 discharged from the hospital on 05/11/2007 (1 months prior to Physician T sappointment). Review of the discharge summary failed to reveal authentication by Physician T. Record review on 08/25/2007 revealed patient # 49 discharged from the hospital on 05/11/2007 (1 months prior to Physician T appointment). Review of the discharge summary on 08/13/2007 (3 months after the patients discharge). Review of the discharge summary failed to reveal authentication by Physician T. Record review on 08/25/2007 revealed patient # 48 discharged from the hospital on 02/09/2007 (4 months prior to Physician T's appointment). Review of the discharge summary on 07/06/2007 (6 months after the patients discharge). Review of the discharge summary revealed Physician T dictated the discharge summary on 07/06/2007 (6 months after the patients discharge). Review of the discharge summary revealed Physician T dictated the discharge summary revealed Physician Physician Physician T dictated the discharge summary on 07/06/2007 (6 months after the patients discharge). Review of the discharge summary revealed Physician responsible for the patients discharge. Review of the discharge summary the patients discharge summary by the physician respons	sum discount plants of the last sum of the las	ummaries, and giver ischarge summaries whysician T has not be are of the patients we has dictated. The ot a process in place esponsible for the pare discharge summarity to verify content of the discharge from the process of th	iven examples of previous ries. The interview revealed of been involved in the patient s whose discharge summaries The interview revealed there is lace to have the physician e patients' treatment to review mary and co-authenticate the tent. 08/25/2007 revealed patient # m the hospital on 02/09/2007 (4 hysician T's appointment). charge summary revealed ded the discharge summary on onths after the patients leve of the discharge summary thentication by Physician T. 08/25/2007 revealed patient # m the hospital on 05/11/2007 (1 hysician T's appointment). charge summary revealed ded the discharge summary on onths after the patients leve of the discharge summary on onths after the patients leve of the discharge summary thentication by Physician T. 08/25/2007 revealed patient # m the hospital on 02/09/2007 (4 hysician T's appointment). charge summary revealed ded the discharge summary on onths after the patients leve of the discharge summary on onths after the patients on the discharge summary on onths after the patients leve of the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on onths after the patients on the discharge summary on on the discharge summary o	A	468			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER		1000	T ADDRESS, CITY, STATE, ZIP CODE OS STERLING ST RGANTON, NC 28655	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 468	51 discharged from the (4.5 months prior to Find Review of the dischard Physician T dictated 07/02/2007 (6 month discharge). Review of failed to reveal co-ausummary by the physiciant's treatment dischargent of the physician of	25/2007 revealed patient # ne hospital on 01/23/2007 Physician T's appointment). rge summary revealed the discharge summary on	A 468			
	against radiation haz adequate shielding for	r patients, personnel, and ppropriate storage, use, and				
	Based on policy and the radiology log, obs physician interview, t minimal radiation exp to shield patients dur. The findings include: Review of the hospita Manual, "Operating a dated 05/31/2007 rev provide the patient, e	procedure review, review of servation, staff interview and the hospital failed to ensure osure to patients by failing ang radiation exposure. It's Radiology Services and Safety Procedure" policy ealed, "It is our policy to mployee, and the public with active lead garment and other				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/	25/2007
	ROVIDER OR SUPPLIER		100	T ADDRESS, CITY, STATE, ZIP COD OS STERLING ST RGANTON, NC 28655	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
A 536	appropriate devices of made. The technology reproductive organs of when possible." Review on 08/24/200 department log dated revealed 95 patient efilms obtained, including KUB/spinal films/abd or hip films and 45 exponsible. Observation on 08/23 radiology department apron. Observation of department room two and one lead pelvices one portable X-ray un Observation failed to available for patients. Interview on 08/23/20 Radiology Manager of shields are not used revealed the manage Collimating" to minimpatients. Continued radiology staff have of during X-rays for the interview revealed peshielded with a pelvic with the test being concept the pelvic and the manager stated require patients to be does not interfere with Interview on 08/23/20 I	when an exposure is being gist will always shield the of all children and adults 17 of the radiology of from August 01- 23, 2007 entries, with a total of 347 ling 33 chest films and 26 ominal series films, 11 pelvis attremity films. 18/2007 at 1150 revealed to room one with one lead revealed radiology of with multiple lead aprons shield. Observation revealed init, with one lead apron. reveal shielding aprons with the portable X-ray unit. 1007 at 1200 with the revealed lead aprons and for patients. The interview er relies on "Coning and nize radiation exposure of interview revealed the not routinely shielded patients past three years. The rediatric patients may be apron if it does not interfere onducted. The interview pron is used infrequently, the hospitals policy does e shielded when shielding th testing.	A 536			

Facility ID: 956125

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUI	LDING	<u> </u>		
		344002	B. WIN	IG		08/2	5/2007
NAME OF PR	OVIDER OR SUPPLIER			10	EET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST IORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 536	aware of Radiology D patients during radiat revealed the physicia patients. I just had an hospital) and they did interview revealed the performs X-rays on a day or 200 patients p interview revealed the hospital's policy requireduce unnecessary interview confirmed the being followed. 482.26(b)(3) MONITO EXPOSURE	s) revealed the physician is repartment staff not shielding ion exposure. The interview in stated "nobody shields in x-ray (at a different in't shield me." The readiology department in average of ten patients per er month. Continued re physician is aware of ring shielding of patients to exposure to radiation. The ine hospital's policy is not		536			
	This STANDARD is a Based on policy and observation, staff interinterview, the hospital monitoring of employed of 3 sampled staff (#1). The findings include: Review of the hospital "Operating and Safety	not met as evidenced by: procedure review, rview and physician I failed to ensure accurate ee radiation exposure for 3					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING _		08/2	25/2007
	OVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 538	When not in use, so the hangers provided also be stored in the state the Secretary's office. Observation on 08/23 radiology staff member monitoring badges. Ophysician in the Radio personnel monitoring revealed one control board. Observation in badges hanging on the Interview on 08/23/20 Technician (RT - staff not store the personn secretaries' office who interview revealed the pocket of her purse a RT carries the purse. Interview on 08/23/20 Radiology Manager (shospital has three radinterview revealed on working this day (staff revealed the staff me on the badge storage revealed staff do not monitoring badges or working. The interview was aware of the hospersonnel monitoring board in the Secretar revealed the Manage	be given a personnel badge tore badges in the office on . The control badge shall same radiation free area in ." bi/2007 at 1210 revealed two ers wearing personnel observation revealed one ology Department wearing a badge. Observation badge on the badge storage evealed no employee he board. bi/2007 at 1215 with a Radiology of #1) revealed the RT does el monitoring badge in the en not working. The er RT places the badge in the er the end of her shift and the out of the hospital. bi/2007 at 1210 with the staff #2) revealed the liology staff members. The er staff member was not of #3). The interview mbers badge was not stored board. The interview	A 538			

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/2	25/2007
	OVIDER OR SUPPLIER		100	ET ADDRESS, CITY, STATE, ZIP CODE 00 S STERLING ST DRGANTON, NC 28655	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 749	RESPONSIBILITIES The infection control develop a system for investigating, and cor communicable disease personnel.	ntrolling infections and	A 749			
	Based on policy and record review and sta staff failed to follow oper hospital policy for (#45, #15). The findings include: 1. Review of the policy revised 12/07/2005 rehave a plan for detection and colon multiple-antibiotic-resemethicillin-resistants (MRSA) and vancom (VRE)The Infection receives a copy of eat assesses it for MRSA as appropriateCon	procedure review, open aff interviews the hospital contact isolation precautions 2 of 5 sampled records by "Resistant Organisms" evealed "The hospital shall tion, prevention, and control sization with distant organisms, specifically taphylococcus aureus ycin-resistant enterocci in Control Nurse (ICN) ich culture report, and and VRE. Action is taken tact Precautions are is with wounds heavily				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		344002	B. WING		08/2	5/2007
	ROVIDER OR SUPPLIER		10	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 749	infection control polic PreventionTo halt in through identification control problems and Medical record review patient #18 was admit 12/22/2006 with the codisorder and remains of a physician assistate 02/14/2007 revealed axilla abscesslarge erythema tender to post the Medical Clinic Produced the Medical Clinic Produced 02/15/2007 rev 0915l/D (incision an Axillae. Specimens-#sensitivity) left axillae amod (moderate) site. notes dated 02/15/20 (abdominal) pad was dressing had become started on Keflex (and review of nursing not revealed "Pt refused underarm." Record review of nursing not revealed "Pt refused underarm." Record review of nursing not revealed "Pt refused underarm." Record review of nursing not revealed "Pt refused underarm." Record review of nursing not revealed "Pt refused underarm." Record review of nursing not revealed "Pt refused under nursing nutries nursing nursing nutries nursing nurs	on Control Nurse's job 'Surveillanceapplication of itesInfection Control and infection transmission and resolution of infection unsafe work practices." of on 08/24/2007 revealed tited to the hospital on liagnosis of schizoaffective hospitalized. Record review int's progress note dated "Patient having pain from left abscess L (left) axilla with alpitation" Record review of ocedure Documentation realed "procedure at did drainage) Abscess Left of C/S (culture and abscess upper site and #2 record review of nursing of at 1355 revealed "ABD applied to L axilla when a saturated. Pt (patient) was cibiotic)." Further record resided to a dressing applied to review of nursing notes dated oversided "Pt picking at resing on wound and area resides dressing at this time x 2." sing notes dated 02/17/2007	A 749			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344002	B. WIN	IG		08/2	5/2007
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 000 S STERLING ST MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 749	messing with wound a Record review of the dated 02/17/2007 rev oxacillin and penicillin notified at 1225." Re assistant order dated revealed "Discontinue hours after the physic notified MRSA was re DS (antibiotic that MF mouth) daily x 7 (ord after lab results notified the left axilla wound). ABD (abdominal) paoregion every shift." Repatient #18 continued Record review failed placed in contact isola infection in his left axi review of the medicat sheet (MAR) dated for 2007 revealed patient dose of the prescribe of the 7 daily doses or review of the MAR rerefused to allow the deperformed 20 out of the was required to be applicated. Interview on 08/25/20 revealed patient #18 wound, had drainage allow a dressing to be MRSA infection, kept hands and refused th MRSA infection. Interhad multiple opporture	arise to place it. Pt seen site with hands. Redirected." laboratory culture report realed "MRSAresistant to inphysician assistant ecord review of the physician 02/19/2007 at 1612 et Keflex (two days and 3 cian assistant had been resistant to keflex)Bactrim RSA is sensitive to) po (per rered 2 days and 3 hours cation to treat the MRSA in Apply dry sterile dressings, if and Telfa pad to L axillary record review revealed if to go to the treatment mall. The reveal patient #18 was realized at the month of February, it #18 had not taken every discording the month of February, it #18 had not taken every discording changes be the 24 times the dressing	A	749			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 S STERLING ST MORGANTON, NC 28655				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM		(X5) COMPLETION DATE	
A 749	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		A 749				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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A 749	same precautions for universal precautions do with all other patie the door is just to let something active." In did not mention the uncaring for a patient or Interview on 08/24/20 Control Nurse (ICN) in the units during tours charts. Interview revewear gloves and a good care and working at the Interview revealed nucleiby the patient is on in	contact isolation as s "you wear gloves like you entsThe contact sign on you know they (patients) got nterview revealed the nurse se of protective gowns in n contact isolation. Or at 1346 with the Infection revealed the ICN observes but does not review patient ealed nursing staff should own when performing wound the patient's bedside. ursing staff are to document contact isolation. Further trising staff had failed to on precautions by failing to o update the treatment plan	A 749				